Missouri Mental Health Task Force

REPORT TO GOVERNOR MATT BLUNT

FINDINGS AND RECOMMENDATIONS

Lieutenant Governor Peter D. Kinder
Chairman

November 29, 2006

Mental Health Task Force Members

1. **Peter D. Kinder**, Lieutenant Governor, Chair
2. **Ron Dittemore, Ed.D.**, Interim Director, Department of Mental Health, Co-Chair
3. **Wendy Buehler**, President, Life Skills, St. Louis
4. **Julia M. Eckstein**, Director, Department of Health and Senior Services
5. **Mark James**, Director**,** Department of Public Safety
6. **Terry Mackey**, President, Arthur Center, Mexico
7. **Gary Sherman**, Director, Department of Social Services (replaced by **Steve Renne**, who became Interim Department Director)
8. **Natalie Woods**, President, Nevada Habilitation Center Family Support Association

The Mental Health Task Force offers this report of its deliberations, findings, and recommendations to the Governor for further action.

We wish to thank the hundreds of Missourians who took time to comment on these issues. It demonstrates not only the level of concern that exists in families and communities for individuals with disabilities, but also a commitment to help those individuals realize the vision of the Department of Mental Health:

> ***"Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse."***

The Task Force acknowledges the contributions of the following individuals for their assistance with the mission of the Task Force: Department of Health and Senior Services—David Durbin and Brenda Campbell; Department of Social Services—Gus Kolillis; Department of Public Safety—Brian Jamison; Department of Mental Health—Mark Stringer, Mary Tansey, Bob Bax, Dottie Mullikin and Miriam Schepers.

Note: For more detailed biographies of those appointed to serve on this Mental Health Task Force, please see Appendix A at the end of this document.

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Overview—The Department of Mental Health

The Missouri Department of Mental Health was first established as a cabinet-level state agency in 1974. State law provides three principal missions for the Department: 1) prevention of mental disorders, developmental disabilities, substance abuse, and compulsive gambling; 2) treatment, habilitation, and rehabilitation of Missourians who have those conditions; and 3) improvement of public understanding and attitudes about mental disorders, developmental disabilities, substance abuse, and compulsive gambling.

The Department of Mental Health (DMH) is organizationally comprised of three program divisions that serve approximately 150,000 Missourians annually, along with six support offices. DMH makes services available through state-operated facilities and contracts with private organizations and individuals. State-operated psychiatric facilities include inpatient services for adults and children as well as the Missouri Sexual Offender Treatment Center. Six habilitation centers and eleven regional centers serve individuals with developmental disabilities. Other services are purchased through approximately 4,000 contracts with privately operated agencies across the state.

There is a seven-member Missouri Mental Health Commission that serves as the principal policy advisory body to the Department Director.

The Department maintains a comprehensive web site at www.dmh.mo.gov and welcomes comments from the public.

Background

In June 2006, the St. Louis Post-Dispatch ran a series of articles describing serious incidents of abuse and neglect of individuals served in facilities and programs operated or contracted by the Missouri Department of Mental Health (DMH). The articles were largely based upon data from 2000 to 2004, the same period that had been the target of reviews conducted by the State Auditor. In response to the State Auditor's last report in 2005, DMH had already begun to implement changes to improve the investigative process for allegations of abuse and neglect. Even so, the Post-Dispatch cited a system of reporting and oversight that was fragmented and at times ineffective.

During the same time period, 21 deaths linked to abuse and neglect at privately run homes and state-run centers were recorded. More recently, two deaths at the Northwest Habilitation Center sent shockwaves throughout the state. This then became the catalyst for immediate action.

> **"*The state must seriously re-evaluate how we go about the inviolable task of providing for those who rely on our care. Every one of us must be able to go to sleep at night satisfied that we have done all in our power to ensure the highest quality of life and safety for the people entrusted to the Division of Mental Retardation and Developmental Disabilities. The state's most basic and sacred duty is the protection of the well-being of the weakest among us."***
>
> **Senator Joan Bray**

Governor Blunt Directs An Immediate Collaborative Effort By State Agencies: Short and Long Term Goals

To reassure Missourians that our most vulnerable citizens were safe, several actions were initiated. Governor Matt Blunt ordered immediate steps to be implemented within the Department of Mental Health:

- The Department of Mental Health was to ensure that a DMH representative participates in every Child Fatality Review Panel evaluation of deaths of children that occur in DMH licensed or certified facilities.
- The Department was to report every child death in a DMH facility to the Department of Social Services State Technical Assistance Team (STAT), and all child deaths were to be investigated by STAT for the next 60 days.
- All reports of abuse and neglect in DMH facilities were to be co-investigated by DMH and the Department of Health and Senior Services for the next 60 days.
- The Department was to immediately notify the Missouri State Highway Patrol and local law enforcement of any death in a DMH facility that is suspicious for homicide.
- The Department was to propose a statutory change that would mandate that all deaths in DMH licensed or certified facilities be reported to the coroner or medical examiner.

In accordance with the Governor's directive, the Department of Mental Health signed Memoranda of Agreement with the Departments of Health and Senior Services and Social Services for joint investigations over a limited period. This created a safety net by tapping into the expertise of sister state agencies. At the conclusion, each agency agreed to provide written feedback on the DMH investigative process

Governor Blunt also appointed a Mental Health Task Force to be chaired by Lt. Governor Peter Kinder to review best practices, to conduct field hearings for obtaining public input, and to make recommendations for changes to the mental health system that will keep children and adults with disabilities safe. This combination of long and short term action was designed to ensure that safety of consumers is built into the very fabric of the DMH service delivery system.

The MO Mental Health Task Force, co-chaired by Lt. Governor Peter Kinder and MO Department of Mental Health Interim Director Ron Dittemore, met on July 11, 2006, at the State Capitol to discuss the current status of the state mental health system and develop long-term solutions for identified problem areas.

Additional Actions by the Department of Mental Health

"All people are treated with respect and dignity and their rights are ensured by persons providing them with services and supports." This is part of the vision, mission, and values developed by the Department of Mental Health. Abuse and neglect are incompatible with respect and dignity. As a result of apparent lapses in safety, abuse and neglect have been documented. The Department acted swiftly to alleviate concerns about the treatment of persons entrusted to its care by implementing the following:

1. The Department directed a study on Direct Care Staff Perceptions of Abuse and Neglect. This was an effort to identify factors within the work environment that: a) lead to instances of abuse and neglect, b) discourage timely and accurate reporting of abuse and neglect, and c) otherwise compromise the process of investigating abuse and neglect allegations and arriving at appropriate dispositions. Since most of the allegations of abuse and neglect involve direct care staff, three teams of such staff, based on facility type, were convened with the assistance of an outside consultant to develop recommendations for reducing abuse and neglect. As a result of their deliberations, the teams grouped the root causes of abuse and neglect into the following categories:
    - Inadequate staffing;
    - Inefficient use of existing staff (how they are deployed to provide coverage and consumer oversight, overtime demands);
    - Inconsistent hiring process (who and how long);
    - Poor staff preparation (initial and ongoing training, mentoring); and,
    - Lack of quality and consistency of supervision (preparing supervisors to lead).

    Recommendations were presented in each of the above categories to reduce abuse and neglect in facilities. Foremost among these recommendations were:

    - Creating a supervisory training program for ward/home /unit managers;
    - Redesigning curricula training/orientation for newly hired employees (consumer attendant trainees, security attendants);
    - Involving staff in hiring decisions;
    - Redesigning the process for assigning staff to consumers who require intensive supervision (one to one); and,
    - Developing administrative processes for managing allegations of employee misconduct that do not directly impact consumer safety, allowing investigators to concentrate on abuse and neglect issues.

2. All DMH residential facilities were directed to conduct a safety review and check of all equipment to determine appropriate level of function. The focus was on basic safety issues such as control of water temperature. Aging equipment in state habilitation centers reflect decreasing populations and the lack of capital improvement funds for maintaining and replacing antiquated equipment.

3. The Director of the Department of Mental Health issued a letter to all DMH employees reminding them of the responsibility to ensure the safety of DMH consumers, reviewing the procedures for reporting suspected abuse and neglect, and encouraging the highest and best service to DMH consumers.

4. The DMH internal analysis of investigations of allegations of abuse and neglect that was begun in late 2005 continued with an emphasis on hiring additional investigative staff to reduce the backlog of investigation cases. The reorganization of the unit as a centralized function to assure uniform safety and reporting standards statewide was sustained within the Director's Office under the Office of General Counsel.

5. A new Director for the Division on Mental Retardation and Developmental Disabilities (MRDD) was appointed with a focus on implementing best practices appropriate to the DMH system, preventing and reporting abuse and neglect, improving communication between regional and central office staff, restoring a focus on person-centered planning, and building quality assurance into all programming.

6. New staff were hired for Northwest Habilitation Center and creative recruitment strategies were implemented at other facilities in an attempt to relieve hiring shortages.

7. Quarterly cross-referencing of the employee disqualification list with the Division of Employment Security for abuse/neglect or misuse of funds was instituted.

8. The Investigations Unit achieved a five working day turnaround time in the completion of investigations of serious incidents of abuse and neglect in all Intermediate Care Facilities-Mental Retardation (ICF-MR).

9. NETWORK OF CARE, a web-based resource access and education program was launched in the summer of 2006; it has begun to greatly facilitate access to critical information and services for DMH consumers, which is relevant to crisis prevention.

10. Hired an Interim Deputy Director of the Department of Mental Health who is charged with attention to prevention, participating in Medicaid reform, ensuring the implementation of the system transformation initiative, and guiding the development of a realistic strategic plan that steers the transition to an integrated system of public mental health care.

Response of the Mental Health Commission

The Mental Health Commission, composed of seven members, is appointed to four-year terms by the Governor, with the confirmation of the Senate. The Commission appoints the Director of the Department of Mental Health, again with confirmation by the state Senate. The commissioners serve as principal policy advisors to the Department Director.

The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interests of consumers of psychiatric services, and a citizen who represents the interests of consumers of developmental disabilities services.

Following retirement of the previous Department Director, the Missouri Mental Health Commission appointed an Interim Director on July 1, 2006, and initiated a nationwide search for a permanent Director. The Commission sought comprehensive information on the full array of factors that contribute to lapses in safety and reviewed internal and external reports. It also sponsored six public hearings and solicited written public testimony on issues of consumer safety and ways to improve services and supports.

The Commission issued a comprehensive report to the Governor in August of 2006. It offered 23 recommendations for improving safety in the mental health system. The Commission's report notes that systems that are most effective at protecting the safety of consumers are those that maximize transparency in decision-making and operations by:

- Establishing a balance of internal and external investigations and quality review mechanisms;
- Building partnerships with consumers, families, staff, and other stakeholders with shared visions and responsibilities for safety and quality;
- Promoting openness, permeability, and accessibility of the facility to stakeholders as well as regulators, partners, and the general community; and,
- Structuring decision-making processes at all levels that rely on data analysis of trends and issues that translate to safety and quality of life for DMH consumers and their families.

The Commission's report also observes that meaningful change, particularly in organizational culture, requires long term strategy and investment in addition to short term actions. Because of different roles and responsibilities within the service delivery system, different perspectives will lead to conflict and disagreement regarding appropriate strategies and resource investment. Accommodation of these legitimate differences to identify creative and mutually sanctioned solutions is the job of effective leaders.

The report can be viewed in its entirety at www.dmh.mo.gov, and the recommendations are referenced here in Appendix C.

Formation of the Mental Health Task Force

In June 2006, Governor Matt Blunt charged Lt. Governor Peter Kinder with forming a special Mental Health Task Force. The Task Force was initially comprised of Directors of the Departments of Mental Health, Social Services, Health and Senior Services, and Public Safety.

The Task Force reviewed its group membership and sought to expand beyond state agencies to include families and representatives of contract service providers. In making this change and appointing three new members to the Task Force, the Governor indicated he was pleased with the action of the Task Force to date. "This cooperative state task force has already implemented several action items and improved procedures that will have a significant and lasting impact on client safety and care," Governor Blunt said. "Adding outside expertise will complement their good work as they continue to review the mental health system to ensure no instances of potential abuse or neglect in public and private facilities are overlooked."

MISSION: The Missouri Mental Health Task Force will make recommendations to the Governor for actions that will prevent abuse and neglect, assure thorough investigation of abuse and neglect allegations, and increase the safety of mental health services for Missourians with disabilities, targeting those served in state-operated facilities and private community-based agencies

Actions of the Mental Health Task Force

Steps for Safety

The first item of business of the Task Force was to ensure that the Department of Mental Health had implemented changes to services that would increase safety for its consumers. The Task Force confirmed that:

- The Department of Health and Senior Services (DHSS) signed a Memorandum of Understanding (MOU) to co-investigate incidents with DMH.
- The Department of Social Services had a Memorandum of Understanding (MOU) concerning the reporting of child fatalities.
- A protocol was established with the Department of Public Safety to ensure that proper law enforcement notifications are performed when any incident of a suspicious nature occurred and that law enforcement expertise was available for investigations as needed.

Members of the Missouri Mental Health Task Force, appointed by Governor Matt Blunt, listen to presentations by Department of Mental Health officials concerning the provision of services to mental health clients on July 11, 2006, at the State Capitol.

Communication with Missouri's Citizens:

The Missouri Mental Health Task Force announced the establishment of an interactive web site to provide information and obtain public input from families, guardians, providers, and other interested persons. Hundreds of individuals responded by submitting comments electronically, all of which were shared with Task Force members.

"Our responsibility is to obtain input from those who are interested in these critical issues," said Lieutenant Governor Peter Kinder, Co-Chairman of the task force. "We are charged with discovering what reforms or changes are needed to ensure that we are fulfilling our duties to these vulnerable individuals."

The web site - www.dmh.mo.gov/mmhtaskforce - included an on-line comment form that individuals were able to access, complete, and submit electronically to Lieutenant Governor Peter Kinder. Information on contacting the Task Force by phone, regular mail, and fax was also available.

"As we study ways to improve our investigation process and oversight responsibilities, we need to know those issues that are important to the parents and guardians as well as the service providers," said Dr. Ron Dittemore, Interim Director of the Department of Mental Health. "These comments are critical for the Task Force as it develops and reports its recommendations to the Governor."

Public Hearings

The Missouri Mental Health Task Force promoted an official schedule of public hearings that were held throughout the state to listen to consumers, families, providers, staff, and others with an interest in the safety of the mental health system.

"We are committed to finding long-term solutions to these issues," said Lt. Governor Peter Kinder, Co-Chairman of the task force. According to Department of Mental Health Interim Director Ron Dittemore, it has provided an outside look at the mental health system, especially its abuse and neglect reporting and investigations, and its oversight of facilities.

"This outside perspective complemented what the Mental Health Commission has done," Dittemore said. "Their recommendations and those of the Task Force will give the state a solid blueprint for meaningful reforms."

"We have a responsibility to solicit public input," Kinder said. "I invite concerned Missourians interested in the care and safety of individuals in our mental health system to share their comments and suggestions."

With several open Task Force meetings already scheduled for Jefferson City, field hearings were planned for St. Louis, Kansas City, Springfield, Joplin, Cape Girardeau and Kirksville.

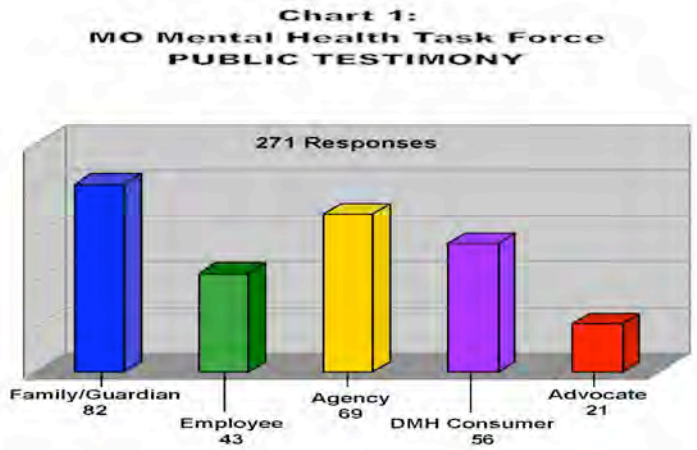


Chart 1 displays the type of public testimony delivered to the Mental Health Task Force. Those testifying were a microcosm of the community and offered a rich variety of opinions for the Task Force to consider, including preventing consumer abuse and neglect.

Some of the hearings were packed with standing room only. Participants included DMH consumers, staff from Missouri Protection and Advocacy Services and other agencies, parents and siblings of children and adults with disabilities, Public Administrators, DMH and contract provider employees, and former employees. The public testimony was varied, passionate, and sometimes distressing as individuals presented personal anecdotes, stories with examples of unsafe situations, proposals for preventing abuse and neglect, and recommendations for changing the investigative process. In addition, feedback was obtained on redesigning the system of services provided under the umbrella of the Department of Mental Health. Support was expressed for a continuum of services ranging from maintaining the habilitation centers with appropriate environmental and staffing upgrades to increasing community-based services, including extensive in-home care. One theme woven throughout public testimony relative to preventing and investigating abuse and neglect, as well as system redesign for all of DMH services, was funding. There was a strong implication that budget cuts imposed over the course of the last 10 years have left the Department with too few dollars to provide services needed by Missourians and to fulfill federal mandates such as implementation of the Olmstead decision.

Many who testified indicated their satisfaction with the system and the services available. They expressed approval for the Department overall, including its service delivery network, and indicated an understanding that no human structure is without flaws.

> ***"And now we come to the most important part of tonight's meeting: your comments; your public testimony..."***

Lt. Governor Kinder opened the public testimony portion of each of the hearings with words of welcome, appreciation, and encouragement. Task Force members listened, asked questions, and acknowledged their gratitude for community members who came forth to share their thoughts, feelings, and experiences. This oral public testimony, as well as the written comments, will continue to be referenced as the Department responds to suggestions for improving its service delivery system. The Task Force thanked each person who participated in the hearings or responded via the web site. It is this very involvement that can change cultures and create acceptance for all individuals with disabilities.

The following suggestions came directly from public testimony and have been grouped according to similarity and patterns.

1. **Staffing.** Across the board, staffing was the area most often mentioned by individuals who testified. They believe direct care staff are doing a great job for the most part but are not fully appreciated. Several commented that staff turnover was a significant problem and provided suggestions for ways to impact retention of employees. Families articulated gratitude for caregivers who were able to give loved ones what they themselves had been unable to give. Low salaries and a lack of benefits (especially access to health care) were mentioned as factors. Budget cuts over the years have reduced the number of staff available for direct care, creating unsafe levels of staffing in some instances. One consequence of this is mandatory overtime in some facilities.

2. **Staff Recruitment, Orientation, and Training.** Testimony from the public, especially from parents and guardians, emphasized the need for staff development. Several expressed the opinion that in the past, significant resources were directed toward training. With budget cuts over the past 10 years, parents feel most training has been discontinued, making it impossible for staff to keep up-to-date on evidence-based practices. Staff themselves cited incomplete background checks, hurried training that is not reinforced after work has commenced, and a discrepancy between expectations and actual work once the job has begun. Several staff offered the opinion that some individuals ought never to have been hired; they wonder if a screening test could be used to make sure an individual's personality is compatible with the work and populations served.

> ***"99.9% of the staff is very dedicated to the well being of residents despite the low pay and tough job demands. Pay them a decent wage so we can retain the staff that are dedicated to the safety of our loved ones. Provide additional training so that staff can respond to any situation that arises and give them the tools to accomplish this."***
>
> ***brother and co-guardian of a resident at Bellefontaine Habilitation Center***

3. **Hotline.** Having access to a hotline so that allegations of abuse and neglect could be made anonymously was suggested. This would be similar to the hotline operated by DSS under child protective services. Parents and caregivers felt that the number of reports would increase once the potential for retaliation was diminished.

4. **Investigations.** The way investigations are handled was of concern to some individuals. There were questions about who does investigations, whether every allegation is investigated, whether they are handled in the same manner, how long it should take, and the role of Missouri Protection & Advocacy. Some felt investigations ought to be assigned to a system independent of the Department of Mental Health.

5. **Quality of Care.** There were strong feelings that budget cuts over the last 10 years have been so deep that the Department of Mental Health is not able to provide the basic services needed by persons with alcohol and drug abuse problems, mental illnesses, and developmental disabilities. Some even described the Department of Mental Health as being abused, neglected, and left unable to fulfill its legislative mandate. There was a sense that the continuum of services provided through a combination of state operated facilities and community-based programs created competition rather than cooperation. Public testimony reflected concern that different standards of care are expected from contracted provider programs versus state operated programming.

6. **Prevention.** In general, it is more effective and efficient to focus on preventing abuse and neglect rather than simply trying to fix the problem after the abuse occurs. The framework for preventing abuse and neglect involves effecting cultural change within the state-operated facilities and community-based programs by creating caring employees, who feel supported in their jobs, who possess the skills and tools necessary to work with the consumers, who are fairly compensated, and who have a passion for their work. There were many comments that the focus must be on preserving safety. A significant number of the suggestions made were directed at *preventing* abuse and neglect.

The literature indicates that consistent disciplinary action for perpetrators once a charge is substantiated can act in the role of prevention. "An affirmative requirement that the facility take prompt and consistent disciplinary action when a charge of abuse or neglect is confirmed by the investigator is prevention that can be reflected in the statutes."

7. **Budget/Funding Issues.** Individuals presenting oral and/or written comments felt that it is clear that many decisions at DMH have been affected by budget cuts. The ramifications of these cuts have been far reaching and have impacted all areas of the Department. Many individuals commented on the need to fully fund services for Missourians who qualify and are eligible, thus eliminating the waiting list. When it comes to service dollars, the sentiment of some testifying was that the Department cannot continue to do more with less. If there is less available, fewer services must likewise be available was the opinion expressed by some in public testimony although they then acknowledged the impact this would have on the waiting list and the resultant delay for services.

8. **New Programming.** Some new programming has the potential to impact the system. In general, the implementation of new services ought to be based on evidence-based information. There were suggestions for new programs and ideas to undertake. Many of these ideas were not related to abuse and neglect but deserve to be reviewed as the Department initiates programmatic changes in the future.

Note that Appendix D contains a summary of all public testimony received and can be found in the back of this report. In addition, oral public testimony is on tape with a summarized transcription, and all written public testimony is preserved in Task Force documents.

Findings of the Task Force

Abuse is anything that causes harm to an individual. Abuse can be physical, sexual, psychological, emotional, or financial. Abuse of people with disabilities, like all forms of abuse, is an abuse of power and control. Neglect occurs when caregivers do not meet the needs of the people they serve. Neglect may involve withholding food, care, or medication. Another form of neglect is when someone does not stop another person who is being abusive. Systemic abuse refers to practices that take away a person's independence and dignity.

The literature indicates that allegations of abuse and neglect of people with mental illness and developmental disabilities is a pervasive problem throughout the nation. Individuals with disabilities are victims of abuse and neglect more frequently than the general population. In fact, a California study estimates they are four times more likely to be abused. Individuals with cognitive impairments are at greatest risk. Task Force findings focused on these areas:

1. Abuse and neglect of people with disabilities is a public health problem because Missourians with disabilities are likely to be:
    - victimized at a much higher rate than other citizens;
    - inadequately educated and supported to recognize, resist, and seek alternatives to abusive situations *(testimony at public hearings in Kansas City, August 4, 2006)*; and,
    - not given aggressive investigative effort when reported to law enforcement.

2. The prior system of protections was inadequate for victims with disabilities because it:
    - lacked adequate monitors to ensure safety for consumers;
    - failed to collect reliable, valid data concerning the scope of the problem;
    - was inadequately funded and staffed;
    - failed to include sufficient prevention initiatives; and,
    - was perceived to be surrounded by secrecy.

The system operating today has been changed significantly since most of the incidents cited by media stories. It is an improved system. The Task Force sought recommendations to make it even better.

Prevention

Individuals with disabilities are among the most vulnerable in our society. We live cooperatively and have an obligation to provide care and protection for those unable to provide for themselves.

The Task Force feels that there must be a shift in the way abuse and neglect is viewed not only within the Department of Mental Health but also in our communities. Creating an

atmosphere of acceptance and appreciation of all individuals, regardless of disability, is the responsibility of every Missouri citizen.

We must actively practice prevention. The best way to prevent abuse is to make sure that anyone who has a disability:

- Is involved in the community.
- Has control over her own life and makes her own decisions.
- Enjoys as much independence as possible.
- Can get information about human rights.

There are simple actions that can be taken by service providers at both state-operated and state-contracted facilities to help prevent the abuse of people with disabilities:

- Appreciate the nationwide risk of abuse of people with disabilities.
- Learn to recognize the signs of abuse.
- Listen to, believe, and take action on allegations of abuse.
- Listen to, believe, and take action on allegations of neglect.
- Recognize and respect the fact that many persons with disabilities are able to exercise independent decision making.
- Provide information on abuse, as well as options and resources.
- Know about victim-serving resources.

A deliberate choice has been made to utilize a *prevention framework* for the Mental Health Task Force recommendations. The prevention framework positions the Department for utilization of best practices and a comprehensive approach in which the whole is greater than the sum of its parts. Prevention means there is an active role for everyone: for consumers and their families, for staff within the public and private sectors, for government, for program administrators, and for every citizen.

"Parents, administrators, managers, employees, even the public do not recognize what behaviors constitute abuse and neglect. If one doesn't know what verbal or psychological abuse and neglect is – or that inappropriate behaviors are occurring – how can it be addressed and corrected? When my son was abused in the back yard of his community apartment, I didn't know until I unexpectedly met one of his neighbors at a bank and was told about the midnight abuse by a staff member. She didn't know how to report the incident."

Mother of a 41 year old son with multiple handicaps who has spent the last 20 years navigating the mental health system on his behalf.

Investigations

Effective September 16, 2005, the abuse and neglect investigation unit was centralized in the Office of the Director of the Department of Mental Health under the Office of the General Counsel along with Consumer Affairs, Hearings and Appeals, Rules and Regulations, and the Employment Disqualification Registry. It is important to recognize that the reorganization and centralization of the abuse and neglect unit in the Office of the Director was initiated as a result of findings from the State Audit covering the time frame of 2000 to 2004. This is the same time frame utilized in the Post-Dispatch articles addressing their concerns of abuse and neglect.

The transition from a decentralized system in which a majority of investigations were conducted by staff with limited training under the direct supervision of Department facilities to a centralized system under the supervision of the Department's General Counsel consisted of developing a comprehensive curriculum; training personnel; reviewing and revising regulations, policies, and procedures governing investigations; and, establishing or relocating regional staff offices.

Under the jurisdiction of the Office of the General Counsel, training was enhanced and brought into alignment with principles of best practice. Forms were developed to create consistency. As new staff members were hired, an emphasis was placed on more sophisticated skills and experience utilizing law enforcement investigative training. On July 1, 2006, the addition of five new positions enabled the Department to move forward and target the backload of investigations. The data system in use at DMH made tracking of incidents and the disposition of cases difficult to manage. Despite significant improvement in the DMH investigative system, some questions have persisted and there was little preventive action throughout the system aimed at decreasing incidents of abuse and neglect.

All DMH employees are required and expected to report suspected abuse or neglect, and employees who report suspected abuse or neglect will be supported by the Department. On the other hand, employees who fail to report abuse or neglect are subject to disciplinary action. In particular, employees who fail to report physical abuse, sexual abuse, instances of neglect that a reasonable person would conclude could result in serious harm to the consumer, or misuse of consumer funds or property, will be terminated.

In addition to reporting suspected abuse or neglect to a supervisor, individuals also may report abuse or neglect directly to the head of a DMH facility or by calling the Department's Consumer Affairs Office toll free at 1-800-364-9687.

The Department has policies and procedures for reporting and investigating allegations of abuse or neglect. Following is the process for state-run facilities:

- Department employees must immediately report to the facility head all alleged abuse and neglect incidents. Employees who fail to report are subject to disciplinary action, criminal prosecution, or both.

- Within 24 hours or by the end of the next business day, after the incident is reported, the facility must enter the incident in the Department's tracking system.

- The facility head (Appointing Authority) must take immediate, appropriate action to ensure the involved consumer(s) is(are) protected from any potential harm during an investigation, including placing staff on administrative leave, if appropriate.

- When an injury occurs, a physical examination of the consumer shall be performed as soon as possible by a licensed physician or registered nurse, as appropriate. Color photographs of any injuries shall be taken and any potential evidence shall be secured. The examination and taking of photos will take place with the consent of the consumer or with consent of the guardian if the person has a guardian. Immediate examination without consent may be necessary when there is a reason to believe that a serious or life threatening injury has occurred.

- The facility head or designee must notify the parent (or the legal guardian) of a minor of the facts regarding the alleged incidents; the Children's Division (if the incident involves a minor); and, law enforcement if the incident is alleged sexual abuse, involves physical injury, or may involve criminal misconduct.

- The facility head must immediately initiate a local investigation or request an independent investigation by DMH Central Office, and resolve the investigation within five days, but not longer than 30 days, unless documented that additional time is needed to complete the investigation.

- Upon completion of an investigation, the facility head shall notify the parent of a minor consumer or a consumer's legal guardian of the investigative findings, a summary of the facts and circumstances, and action taken, except that the names of any employee or other consumers shall not be revealed. The report shall be open to the parent or other guardian of the consumer, per RSMo 630.167 (3) (1).

The Department must disqualify from employment any person, after appeal, found to have committed abuse/neglect or misuse of consumer funds/property.

Deaths

The Department makes every effort to serve as a support to family, friends, and staff when a consumer dies. In addition, the facility staff always assists with final arrangements, returning property to appropriate persons, and any other support they can provide. The facility head must immediately report all deaths to the Department.

- The facility head must immediately enter the death in the Department's event tracking system and update the system with the death review information within 45 days.

- The facility head must immediately initiate and complete a death review within 45 days on consumers in placement or consumers who die while receiving a Department funded service.

- The facility head must request a DMH Central Office investigation if there is an allegation or suspicion that the death is a result of abuse or neglect.

- If there is a suspicion of wrongful death or an allegation or suspicion that the death is a result of abuse or neglect, the facility head will inform and cooperate with the local police, Children's Division, Department of Health and Senior Services, Missouri Protection and Advocacy Services, and the Central Office Investigative Unit as appropriate.

Reports from Other State Agencies

In accordance with the Memoranda of Agreement negotiated, input was received from other state agencies. Weekly conference phone calls were held with all the state agencies to exchange information. Inconsistencies identified during these phone calls were immediately reviewed and incorporated into DMH procedures as appropriate, thus improving the investigative system on a weekly basis.

The Department of Health and Senior Services (DHSS) conducted joint investigations at Intermediate Care Facilities (ICF/MR) operated by DMH during the 60 day monitoring period. In total, 64 cases were jointly investigated and the DMH investigative process was analyzed. DHSS recommended the following for DMH:

- Make unannounced monitoring visits.
- Implement consistency of treatment of non-certified and certified clients relative to the time frame for investigation conclusions.
- Implement a triage process to address serious cases and use law enforcement investigative expertise.
- Streamline the investigative process by interviewing staff on a single shift.
- Include Root Cause Analysis in analysis of fact.
- Develop a formal system for reporting allegations.
- Determine the need for increased numbers of DMH investigators.
- Develop a training protocol for all DMH investigators, including a review of policies and procedures, as well as on-the-job training.

The Department of Public Safety, Missouri State Highway Patrol, partnered with DMH for the 60 day period to review all deaths and/or assaults within a Department facility. The Department notified the Missouri Highway Patrol and local law enforcement at the time of the occurrence. Law enforcement cooperatively reviewed and/or investigated the reported

incident. The Highway Patrol reviewed 237 incidents statewide. In every case where follow up was indicated, the Highway Patrol found the incident appropriately managed. On several occasions local law enforcement opened investigations. This agency recommends:

- DMH hire or contract with an employee to serve as an evaluator of all incidents of deaths and assaults to act as a liaison with state and/or local law enforcement. This person should have a criminal justice background and not be attached to a facility or habilitation center.
- DMH should develop reporting criteria to communicate incidents to law enforcement.

The Department of Social Services, STAT team, investigated all child deaths under its existing system for child fatality review. This process shall continue beyond the 60 day interim period. DSS/ STAT recommend that DMH:

- Provide specialized training for those caring for persons with disabilities.
- Evaluate and use trainers and curricula specific to mental health and institutional investigation protocol.
- Develop a protocol that defines and limits cases investigated.
- Develop a protocol to include a 24/7 triage mechanism.
- Investigate all consumer deaths for accountability.
- Provide authority to the Investigative Unit to review all records.
- Develop a reporting format that includes time frames for preliminary updates and the final report for an investigation.
- Appoint a five-member independent expert panel to review death and other reports. Appointed by the Mental Health Commission, the panel should include law enforcement, a forensic pathologist, a medical doctor, a mental health professional and an institutional social worker.

The Investigative Unit operating under the Office of General Counsel has implemented several of these recommendations (the triage protocol; more comprehensive reporting format; specialized training; an evaluator; consistency of time frame; root cause analysis; analysis of staffing needs) already. Others have been incorporated into the recommendations of this Task Force (establish a hotline; establish a triage procedure). A few of the agency recommendations are still under consideration. DMH has appreciated the time and talent dedicated to this initiative by the other state agencies; their feedback has been invaluable to this process.

Prevalence Data

The Task Force wanted to determine where abuse was occurring and why. Over the past three decades, there has been a concerted effort in the United States to move people with developmental disabilities out of large institutions, which had long been criticized for being overcrowded and isolated. The effort to move people into smaller group homes has succeeded in bringing developmentally disabled persons into communities where they can learn new skills, get jobs, or attend special schools. But this progress has come at a price. It has strained the systems that support people living in the smaller settings and

created gaps in oversight. As recently as 25 years ago, people with developmental disabilities lived in about 16,000 publicly funded homes. Today, they are scattered in about 140,000 homes throughout the nation.

"The systems of quality monitoring have really been taxed beyond what they can manage," says Charlie Lakin, who heads a University of Minnesota program that tracks services to people with developmental disabilities. "By and large, a lot of it is pretty loosely organized and pretty loosely monitored." (The Wall Street Journal, September 13, 2005)

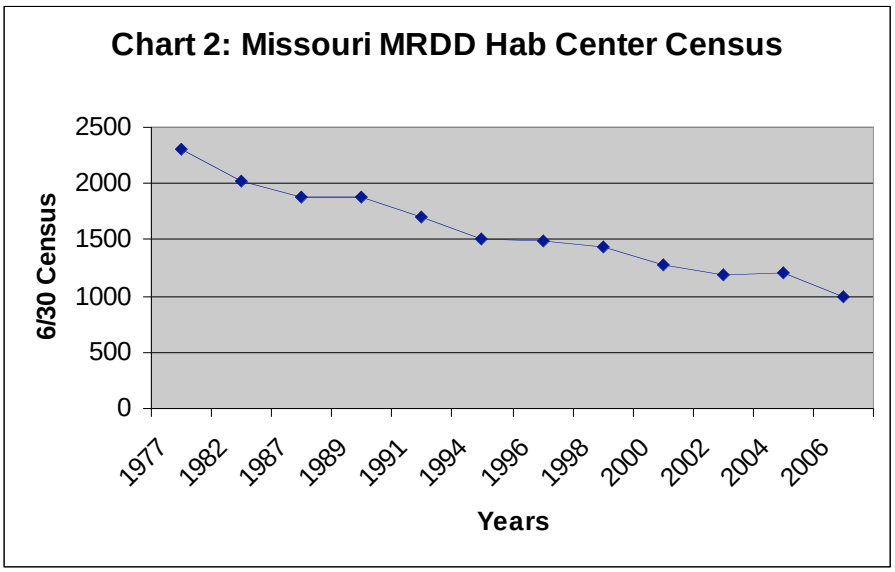


Chart Number 2 displays the institutional population of Missouri's citizens with mental retardation/developmental disabilities as of June 30 beginning in 1977 and ending with June 30 of 2006. Missouri has followed the general trend documented throughout the country: from 1977 through 2006, the population in state-operated facilities declined steadily from 2,308 to 989.

Year	1977	1982	1987	1989	1991	1994	1996	1998	2000	2002	2004	2006
6/30 census	2308	2018	1874	1885	1703	1500	1494	1437	1278	1183	1204	989

Between 1977 and 2006, there was a continuing increase in the total number of persons with developmental disabilities receiving residential services. Data reflects real changes in where consumers were living; fewer were residing in state-operated institutions. Simultaneously, the number of persons served in residential settings having fewer than 16 beds has increased significantly. This means oversight had to be stretched to cover more facilities at a time when budget cuts throughout the state meant fewer personnel were available – the opposite of what the data justified.

The Missouri Department of Mental Health conducts investigations into allegations of abuse and neglect at state operated mental health facilities and at contracted providers of mental health services all around the state. The Task Force further looked at where abuse was substantiated and found again that the data told a story.

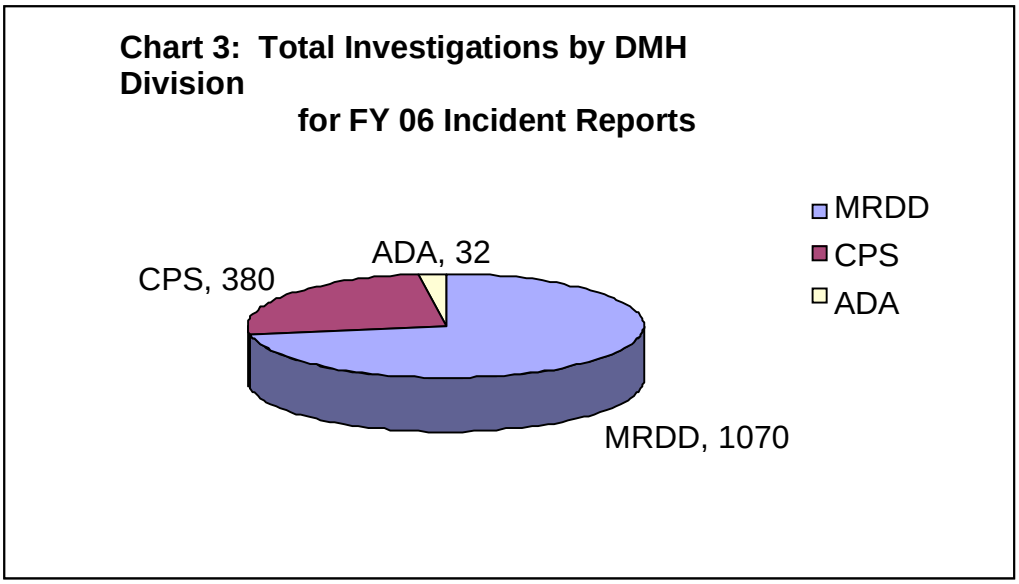


Chart 3 displays the number of investigations of allegations of abuse and neglect during FY 2006. Chart 3 summarizes the 1,482 investigations that relate back to incidents occurring (or alleged to have occurred) during the period July 1, 2005, through June 30, 2006. As can be seen, the majority of investigations related to services provided under the oversight of the Division of Mental Retardation and Developmental Disabilities (MRDD). This division accounted for 1,070 investigations; 72% of all those completed in FY 06. Research indicates that cognitive impairment is the greatest risk factor for abuse and neglect; consumers served by the Division of Comprehensive Psychiatric Services (CPS) and the Division of Alcohol and other Drug Abuse (ADA) are more likely to be assertive and report abuse. The Chart 3 figures are not *substantiated* abuse and neglect investigations because some findings had not been determined at the time this report was written. Those numbers combine the investigations at state facilities and community providers.

Within MRDD, allegations and substantiations occur both within the state operated habilitation centers and community provider facilities. These numbers are difficult to compare as more than 33,000 consumers are served annually in community settings compared to under 1,000 in habilitation centers. The individuals in habilitation centers likely present complex disabilities and are there throughout the year. The consumers served within the community may represent only a few hours of service each month. Nevertheless, the data dictates that prevention efforts should target the consumers served by MRDD both in habilitation centers and in community based settings.

The additional level of detail in the following Chart 4 is to further categorize the investigations as having found abuse or neglect, having found there was no abuse or

neglect, or as still pending. It counts an investigation as substantiating "Abuse/Neglect" if any charge is substantiated by that investigation, even if several other charges are not. Conversely, an investigation is counted as finding "No Abuse/Neglect" only if none (of up to as many as 6) of the allegations are upheld by investigation. By this measure, 607 of the 1,310 investigations concluded so far have lead to 1 or more substantiated charges of abuse or neglect. This represents a 46% substantiation rate.

Chart 4: Investigation Results* for FY 06 Incidents

		Abuse/Neglect Substantiated	No Abuse/Neglect Substantiated	Determination Pending **	All Investigations	Average Daily Residential Census
Community	ADA	5	23	4	32	2384
	CPS	20	31	9	60	3473
	MRDD	341	311	113	765	5470
	Subtotal	366	365	126	857	11327
Inpatient	CPS	98	183	39	320	1470
	MRDD	143	155	7	305	1048
	Subtotal	241	338	46	625	2518
Total		607	703	172	1482	13845

* as of 10/26/2006 ** these allegations are still open, no determination is available

Chart 4 allows a comparison not only among the three divisions of DMH, but between allegations in residential programming operated by the state and by community providers. Care must be taken in drawing conclusions, as in general, the MRDD state inpatient individuals represent a complex and vulnerable population. The average residential census is offered to present the disparity in services – the populations of the habilitation centers are stable with little variation. Especially in other divisions, consumers enter and exit programs with greater frequency.

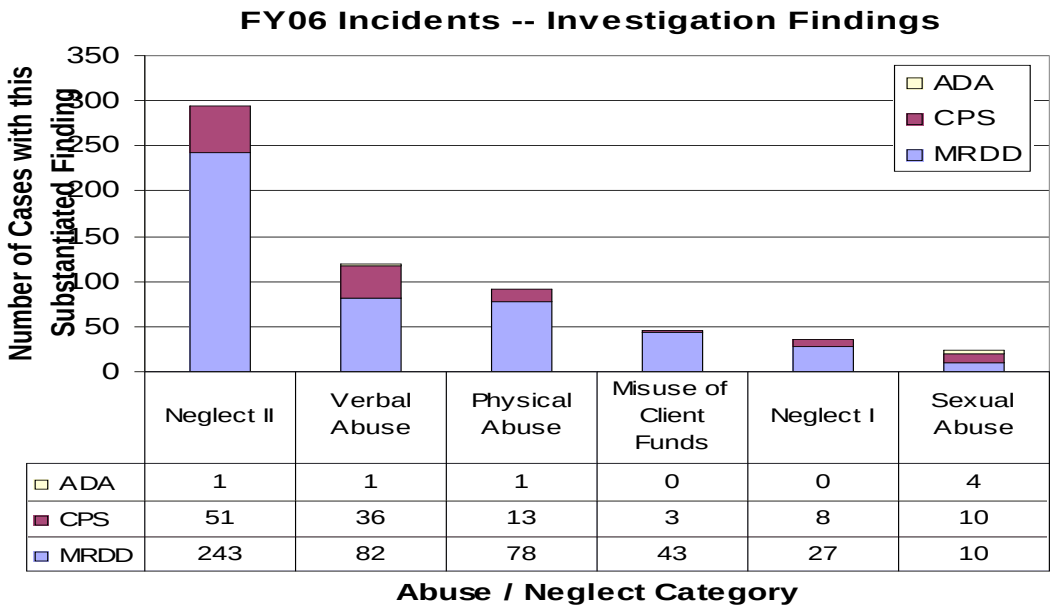
The data in Chart 4 documents 366 cases of substantiated abuse and neglect within community provider programs for 11,327 residential census days for a rate of .0323. Within state-operated programs, there were 241 substantiations for a census of 2518 for a rate of .0957. In the community, 42.7% of all investigations have abuse and neglect substantiated while in state operated facilities, that figure was 241 out of 625 or 38.6% substantiated.

The challenges in understanding the information presented by this data highlight the difficulty in analysis to determine patterns. Each year, the information available is more sophisticated, yet the complexity surrounding abuse and neglect means that the causes remain elusive. It requires the cooperation of consumers, family, friends, staff, administrators, and community members to be vigilant in refusing to tolerate abuse and neglect.

It is also important to analyze the kind of abuse and neglect being experienced within mental health facilities and programming. There was significant criticism of the investigative process utilized by DMH in treating all types of allegations with equal attention. Chart 5 is a snapshot of investigative findings during FY 06. It should be noted that the 611 findings of abuse or neglect detailed below is greater than the 607 investigations that included at least one finding on Chart 4; the difference illustrates the fact that some investigations lead to more than one finding. Chart 5 points to the number of investigations leading to substantiation in the various categories of abuse or neglect, as defined by Department Operating Regulation. Neglect II is by far the largest category, accounting for 48.4% (295/611) of all findings. Neglect II is the failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidation, causing fear or otherwise creating undue anxiety.

Verbal abuse then accounts for an additional 19.5% (119/611) of the findings. Verbal abuse and the Neglect II category together account for slightly more than two-thirds of all substantiations of abuse or neglect.

Chart 5:



	Neglect II	Verbal Abuse	Physical Abuse	Misuse of Client Funds	Neglect I	Sexual Abuse
ADA	1	1	1	0	0	4
CPS	51	36	13	3	8	10
MRDD	243	82	78	43	27	10

Chart 5 displays the various categories of abuse and neglect. Missouri definitions of each category can be found in Appendix F. It is noteworthy that nearly half of all findings involve Neglect II. This information will assist in guiding the development of training protocols for the future.

Summary of Task Force Findings

The results of Task Force deliberations and consideration reveal clear direction:

1. Abuse is a problem and should be analyzed using the public health model.

2. There have been inconsistencies in the investigative process.

3. The prior system was inadequate for maintaining consumer safety.

4. The level of prevention programming is inadequate at this time.

5. Staffing is the key to quality programming for DMH consumers.

6. Neglect II accounts for 48% of all findings; Verbal Abuse and Neglect II account for two-thirds of all substantiated abuse and neglect.

7. Of all DMH investigations, 72% occurred in programs under the oversight of MRDD.

8. MRDD inpatient (habilitation center) days accounted for 12.8% of total days, yet they accounted for 28.5% of investigations during FY 2006. Substantiated abuse and neglect was higher in state operated programs than community provider-operated programs: 366 cases for 11,644 residential days for a rate of .0314 compared to 241 substantiations for 2518 residential days yielding a rate of .0957.

9. Data continues to be elusive, incomplete, and challenging to analyze for patterns.

In light of these findings, the Task Force crafted its recommendations.

Lt. Governor Peter Kinder (left) and Missouri Department of Mental Health Interim Director Ron Dittemore (right) listen to presentations at the Missouri Mental Health Task Force Meeting held on July 11, 2006.

Recommendations

PREVENTION

1. The Department of Mental Health shall pursue survey readiness towards national accreditation of its six habilitation centers and contracted community providers serving persons with developmental disabilities.

JUSTIFICATION: In seeking national accreditation, the goal is to raise the bar of program quality across the board. It is a form of prevention—a way to instill respect for those who work with our consumers and for the consumers themselves. Even so, we must be careful to avoid breeding "an attitude of compliance with regulation rather than reinforcing the sense of mission that draws so many people into this field" *(Clarence Sundram, Accounting and Reducing the Costs of Regulation).* National accreditation across the entire MRDD system will enhance consistency, reliability, and safety. Accreditations should not be pursued at the expense of, or as a replacement for, careful and vigilant regulatory oversight from state and federal bodies. Accreditations cannot replace actual oversight. The state-operated facilities benefit greatly from federal oversight. Governments must actively regulate, monitor, and inspect all facilities and ensure that the same standards of care and safety apply across the board into private care as well.

This recommendation was also a recommendation of the Mental Health Commission.

IMPLEMENTATION: Department initiative; budget item.

2. The Department of Mental Health shall work with the Department of Health and Senior Services to establish formal ties to its adult abuse hotline, and with the Department of Social Services for formal ties to its child abuse hotline, so that reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.

JUSTIFICATION: Utilization of a hotline is regarded as a Best Practice that has been instituted by other states. Public testimony from several citizens indicated that the public in general is unsure of how to report suspected abuse and neglect, which may mean that it is underreported. A hotline that is promoted through training, providing brochures to families and the public,

and the use of print and electronic media will get the message out that abuse and neglect is not acceptable and that something can be done about it.

> ***"Our family and community believe every effort should be made to support individuals and families receiving services which allow them to provide care for their family members in their home or a community setting of their choice.***
>
> ***Our family also believes that when we work to create a real life in the community for individuals with disabilities, when they have friends, family and community connections, they are at far less risk of abuse and neglect."***
>
> ***- Mother of a 19 year old son with disabilities***

IMPLEMENTATION: Department initiative; interdepartmental agreements, budget item.

3. The Department of Mental Health and community providers shall develop standard individualized training for consumers and families on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.

JUSTIFICATION: Training may be the most important factor in ensuring that individuals with disabilities are protected. Providing individuals with information honors their independence and encourages responsible action on behalf of others. This strategy forms part of the spectrum of prevention. Training can negate the following issues:

- People often have negative attitudes about disability.
- People with disabilities are often socially isolated.
- People with disabilities are often in relationships where another person controls the decision making.
- People with disabilities may need to rely on others for the necessities of life, including intimate personal care.
- When abuse happens, people with disabilities may not be believed, may not know what their rights are, or may be unable or afraid to complain.

To be effective for consumers, training needs to include assertiveness training. Personal safety training teaches individuals how to recognize when they are being abused, how to respond to abusive situations, and how to

stay safe. As staff, families, and consumers develop the annual individualized plan of care, training will be addressed and personalized according to the consumer's needs.

IMPLEMENTATION: Department initiative; budget item for training**.**

4. The Department of Mental Health shall amend its Departmental Operating Regulations (DORs) and administrative rules to require standardized training based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.

JUSTIFICATION: Lack of standardization was mentioned by public input. Since 2005, the Department has made great strides in this area and needs to complete the initiative with the Department of Public Safety. Consistent training becomes a prevention practice when it is standardized and becomes part of predictable operating procedures.

This recommendation has some commonality with one of the recommendations within the Mental Health Commission's Report.

IMPLEMENTATION: Administrative rule and DOR change. As suggested by the Mental Health Commission's recommendations, a fixed portion of facility operating costs should be dedicated to training and continuing education for staff.

5. The Department of Mental Health shall redesign its process for licensure and review of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.

JUSTIFICATION: The current practice of renewing certification every two years and licensure every year may be inadequate for ensuring safety. More frequent reviews of care and safety can act as a deterrent to abuse and neglect. Communication between the Investigative Unit and MRDD will assure consumers that problem areas will be addressed. Families, guardians, and individuals with developmental disabilities must be allowed a significant role at all stages of Departmental planning. They are uniquely qualified to assess quality of care and have a contribution to make in the creation and implementation of policy.

Public and private care facilities should be held to the same standard of care. There should be no double standards in safety and scrutiny measures (police reporting, videos, inspections, standards, staffing levels, training of staff, and level of care provided). The state must establish equality in oversight, staffing and protocols to ensure safety in private facilities as well as state operated centers.

IMPLEMENTATION: Department initiative.

6. The Department of Mental Health shall pursue legislation and amend regulations involving Licensure & Certification to permit administrative actions, up to and including fines, for failure to implement plans of correction.

JUSTIFICATION: There is a sense that abuse and neglect is the result of individual action. In fact, part of the challenge is the need to create a supportive culture within both state operated facilities and contract providers so that the working environment reflects that the facility as a whole is dedicated to quality. Once this cultural shift is made, the support generated spreads throughout the facility from the top boss to the consumer. Accountability for quality begins with the facility and is the ultimate responsibility of each employee. The possibility of fines will communicate the serious intention of the Department to make progress toward this goal.

IMPLEMENTATION*:* Legislative and Department Initiative.

7. The Department of Mental Health shall pursue legislation and amend regulations that permit fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect, based upon organizational misconduct.

JUSTIFICATION: Facilities and provider agencies are charged with actively participating in creating a climate where consumers are respected. We know from the findings related to prevention that this is the foundation of preventing abuse and neglect. When an allegation is substantiated, there may be organizational responsibility as well as individual culpability. Fines can call attention to the determination to reduce abuse and neglect and give staff a reason to report without thinking. There is an organizational responsibility to respect consumers and guard their safety. Failure to do so involves both individual caretakers and the facility environment. Placing a facility on "probationary" status may be a catalyst for positive change.

Some employees fear retaliation by their supervisors. The possibility of organizational responsibility will be supportive to staff and encourage legitimate reporting of all allegations. A report of seven states conducted by the Department of Health and Human Services in 2001 determined that state agencies which appeared to have had the most assurance that incidents were reported provided facility operators and other service providers with clear and consistent guidance on how to identify reportable incidents, and had established procedures and time frames for providers and others to follow in reporting incidents. Working collaboratively will improve the reporting of abuse and neglect allegations.

IMPLEMENTATION: Legislation and Department initiative.

8. ***The Department of Mental Health must improve the quality of care by enhancing the salaries of direct care staff to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.***

JUSTIFICATION: As part of building capacity within the community, the state must support the people who are at the heart of this work – front-line direct care staff and their supervisors. Consumers' lives depend on the judgment of these workers. Good leadership is crucial. The Department must review supervision to ensure it is supportive and appropriate both for day-to-day work and for emergency situations. Appropriate orientation and supports must be in place for newly hired staff.

This is also a recommendation of the Mental Health Commission.

IMPLEMENTATION: Department initiative; budget item.

9. The Department of Mental Health must implement an information management system that can rapidly and effectively track critical data on abuse, neglect, and other safety information. This data will be used as a component of the Department's continuous quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc. for both public and community based care.

JUSTIFICATION: The ability to analyze information is a valuable prevention tool. Data can be used to identify trends and patterns of abuse, the causes of abuse, and potential strategies for prevention. Trends and patterns should be examined over time, within each facility and Division, and should take into account each facility's population. Consideration must be given to:

- the method used to count group incidents;
- the extent to which multiple abuses that occur within the same incident are counted; and,
- whether abuse/neglect allegations that are related to clinical judgment are included in data collected.

The Department began utilizing a new consumer data system in October 2006. The Investigative Unit needs to determine if current fields are adequate for tracking abuse and neglect cases or whether modifications or addendums are necessary to meet the information needs of this area. Results should be reviewed at least quarterly.

Collection and analysis of data regarding safety measures must be adequate to identify trends and corrective action as necessary. The system must be able to compare safety performance to other public mental health systems or other comparable facility types. Regular reports must be compiled for public review related to safety performance.

DMH consumers cross many departmental boundaries for their care. As it stands now, issues within the system concerning the well being of these people can slip through the cracks due to a lack of communication and coordination between departments. By linking departmental activities together in a central data system, all information concerning inspections, investigations, etc. by any participating department can be tracked, plotted, and linked to track patterns of abuse, neglect, and related issues.

This is also a recommendation of the Mental Health Commission.

IMPLEMENTATION: Department initiative.

10. ***The Department of Mental Health shall review completed investigations and explore Root Cause Analysis for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.***

    JUSTIFICATION: Investigations based on DMH's current procedures focus on identifying individual actions and do not identify system failures or identify root causes of identified areas or systems in the habilitation centers/facilities. Interviews with the facility staff indicated they often work double shifts, working anywhere from 50-60 hours a week. Many of the employees expressed feeling tired and stressed by the end of their shifts. Current investigation complaint procedures do not include evaluating systems within the habilitation centers/facilities themselves and identifying system failure. Presently, investigations are limited to the individual's failure or actions and investigators do not routinely evaluate the habilitation centers'/facilities' actions.

    IMPLEMENTATION: Department initiative.

11. ***The Department of Mental Health shall make a clear and unequivocal commitment to providing public and community based services that afford real choices for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis. To that end, no habilitation center shall be closed as long as there is a need for its continued operation. Conversely, any habilitation center for which there is no need shall be closed.***

    JUSTIFICATION: Clearly, the treatment and care of persons with mental illness, mental retardation, and developmental disabilities have advanced dramatically over the last 50 years. Drug treatments, therapies, counseling, and supported living arrangements have replaced large, institutional residential placements for many, however not all, persons with disabilities. They also have expanded services to many individuals who previously would not have received help.

    Having meaningful choices and respect are powerful affirmations for individuals with disabilities. Choices become prevention strategies. The maintenance of a true continuum will allow the Department to increase its

focus on the cost effectiveness and efficiency of services while continuing to moving toward consumer-directed care. This helps fulfill the mission of supporting people with disabilities and their families to achieve what is important to them. Adults should receive services where they are likely to benefit most. The goal of intervention is to increase the level of functioning while promoting health and safety. Decisions must be made on an individual basis and consistent with best practices and the Olmstead decision.

Families, guardians, and individuals must have the freedom of CHOICE as determined by the Olmstead decision. They should have a choice of specialized, quality state care options or quality community care options, whichever will best meet the needs of the individual consumer. That freedom of choice is diminished when facilities are closed and downsized

Specific guidance accompanying the Olmstead decision cautions states against construing the decision as a means by which to close facilities. We need to recognize the value of state-operated centers and their ISL homes (individualized supervised living).

IMPLEMENTATION: This will require the collaboration of the Governor, legislators, the Department, consumers, and their families. Budget action for capitol renovation and facility upgrades will be a necessity.

12. The Department of Mental Health shall review Department policies and procedures, and ensure that the health, safety, and welfare of all its consumers are the first and foremost priorities of all employees -- investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.

JUSTIFICATION: The current investigation focus is more of a punitive system for employees/staff, rather than a means to assist in the safety/well-being of consumers, ensuring quality of care and quality of life. The review should address the benefit of allowing investigators to accept additional cases of alleged abuse/neglect while at the facility to ensure protection of consumers. By consistently putting consumers first, every act has the potential to prevent abuse and neglect.

IMPLEMENTATION: Department initiative.

13. ***The Department of Mental Health shall amend its regulations to create a process to require providers to conduct background checks on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.***

    JUSTIFICATION: Timing is a critical issue. Sometimes the delay currently allowable under statute makes re-offending a possibility. To afford the greatest protection for DMH consumers, more immediate action is desirable.

    IMPLEMENTATION: Legislation and Department initiative.

14. ***The Department of Mental Health shall pursue legislation providing civil immunity to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.***

    JUSTIFICATION: The ability to give and receive honest feedback on employee job performance is critical to the hiring of competent staff. Fear of litigation often compromises the degree of honest communication regarding job performance. This recommendation is intended to allow simple, open dialogue regarding work performance. When incorporated appropriately, this becomes yet another way to prevent abuse and neglect and ensure the safety of DMH consumers.

    IMPLEMENTATION: Legislation and Department initiative.

INVESTIGATIONS

15. ***The Department of Mental Health shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish review of all deaths of adults who are in the care and custody of the Department of Mental Health. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.***

JUSTIFICATION: The intent of this recommendation is to ensure absolute accountability relative to a death. Diligent review by skilled professionals can uncover patterns not immediately apparent.

As was noted in the findings, there is a perception of secrecy about investigation of abuse and neglect. The proposed legislation would create an open process of review. A DMH Commission report recommendation also addresses this issue. It is anticipated that about 20 incidents per year would be examined. In the data for FY 2006, Chart 6 categorizes deaths with findings. Chart 6 below provides a view of investigations with abuse and neglect (A/N) findings by incident category. During FY 2006, there were 3 deaths that had been investigated for abuse and neglect.

Chart 6: FY 06 Incidents -- Investigation Findings by Incident Category

Incident Category	Neglect II	Verbal Abuse	Physical Abuse	Misuse of Consumer Funds	Neglect I	Sexual Abuse	All Findings
All Deaths with A/N Findings	1	0	0	0	2	0	3
All Injuries with A/N Findings	39	9	22	0	4	1	75
All Non Injury incidents with A/N Findings	255	110	70	46	29	23	533
All Incidents with A/N Findings	295	119	92	46	34	24	611

IMPLEMENTATION: Legislation.

16. The Department of Mental Health shall pursue legislation to allow public access to non-confidential information in final reports of substantiated abuse and neglect.

JUSTIFICATION: Many states are opening their records to public scrutiny. The Department feels it is important to give consumers and their families access to information that can assist them in decision making about the supports necessary for maximum independence in conjunction with safety. Such release would be at the sole discretion of the Director of the Department of Mental Health, based upon a review of the potential harm to others within the immediate family.

This is also a recommendation of the Mental Health Commission.

IMPLEMENTATION: Legislation; training for consumers, families and staff.

17. ***The Department of Mental Health shall develop a process for triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.***

    JUSTIFICATION: The findings make it clear that DMH contact with law enforcement has been limited and inconsistent. This triage arrangement allows resources to be focused on the most serious cases of abuse and neglect while capitalizing on the investigative expertise of law enforcement personnel.

    This recommendation has some commonality with one of the recommendations within the Mental Health Commission's Report.

    IMPLEMENTATION: Department initiative; legislation; interdepartmental agreements.

18. ***The Department of Mental Health and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures—though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.***

    JUSTIFICATION: Many incidents of employee misconduct that do not result in injuries to consumers have been investigated by the Central Office Investigation Unit. Data shows that a high percentage (48%) of all substantiated investigations is for Neglect II, which generally does not involve any injury to the consumer. Because this is essentially employee misconduct, the proposed recommendation presents a viable solution to the problems of investigative quality and resources without compromising consumer safety.

    IMPLEMENTATION: Department initiative; administrative rule and Department Operating Regulation (DOR) amendments; supervisor training; tracking system.

19. The Department of Mental Health shall enhance its investigations process by evaluating recommendations from the sister agencies on this Task Force and implementing all that are feasible.

JUSTIFICATION: The Departments of Public Safety, Social Services, and Health & Senior Services represent solid expertise in the field of abuse and neglect. DMH provides the expertise in persons with disabilities. Lessons learned from recent collaboration will improve the current DMH system. Note that several recommendations from other the state agencies have already been implemented. (This information is contained in the findings section.)

IMPLEMENTATION: Department initiative.

20. The Department of Mental Health shall evaluate the number of investigations completed by the Investigations Unit and determine the appropriate number of investigators needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.

JUSTIFICATION: These measures should help DMH meet its time lines and ensure complete, thorough investigations. Efficiency in the current interview process could be improved, namely the practice of accommodating facility staff based on their work hours and days of work. Often, multiple onsite visits to the facility were needed to complete interviews, continuing for several days. Alleged perpetrators or other witnesses did not always appear for their scheduled interviews. Immediate statements were not consistently obtained prior to placing the staff person on administrative absence, allowing time for multiple alleged perpetrators to work on providing a "consistent story."

The investigator should work with the habilitation center/facility to ensure staff are aware of the importance of cooperating with an investigation. Cooperation with an investigation is and should be a condition of employment. The habilitation centers/facilities should have a role in ensuring accurate contact information is obtained and maintained regarding their staff. Habilitation centers/facilities should assist in ensuring witnesses appear as scheduled, return phone calls, and not delay investigations. Witnesses and alleged perpetrators should be advised of the consequences of not cooperating with an investigation. While there may be an efficiency in scheduling interviews when staff members are normally scheduled to work, doing so takes away time from their consumer care duties. Interviewing staff members when they are not scheduled to work would minimize time away from consumers.

IMPLEMENTATION: Department initiative.

OVERSIGHT

21. The Department of Mental Health shall work with the Mental Health Commission to implement the Commission's recommendations to the fullest extent possible.

JUSTIFICATION: Many of the 23 recommendations from the Missouri Mental Health Commission are reflected or supported in these Task Force recommendations. The fact that some were not directly addressed by the Task Force does not diminish their significance. They all warrant serious reflection. In considering the Commission's recommendations, the potential conflict between providing a continuum of care option and cutting services commensurate with budget reductions coming from the Executive or Legislative arms of government requires full discussion and resolution.

IMPLEMENTATION: Department initiative; implementation of some recommendations will require legislation and budget action.

22. The Department of Mental Health's Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.

JUSTIFICATION: Federal legislation has established guidelines for protection and advocacy systems in every state and territory to assist with the responsibility of protecting the rights of individuals with disabilities. The Governor-designated system in this state is Missouri Protection & Advocacy Services. It is important to cooperate with that agency in a way that meets the federal mandate yet maintains an arm's distance relationship so that neutrality and advocacy are preserved. Institutional staff, families, consumers, and many community providers who contract with the Department are unaware of the responsibilities of Missouri Protection & Advocacy Services for investigating abuse and neglect allegations and would benefit from training.

IMPLEMENTATION: Department initiative.

23. The Department of Mental Health shall pursue legislation to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.

JUSTIFICATION: The Task Force believes that protective services for individuals with disabilities should be strengthened. In most other states, statutory requirements are within the criminal code—the place to which law enforcement officers most often turn for clarification of responsibility. Several states include penalties for non-reporting of abuse and neglect of individuals with disabilities. The amount of the penalty may be largely symbolic, but the purpose is to draw attention to the issue.

It is absolutely critical that investigative entities speak the same language. Therefore, legislative language should be structured to resemble the child protection statute as closely as possible.

IMPLEMENTATION: Legislative initiative; Departmental collaboration; budget item for training.

24. The Department of Mental Health, Division of Mental Retardation/Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of public-private partnerships to deliver case management services, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.

This committee should examine proposals to transfer many of the functions provided by the 11 Regional Centers currently operated by the Department of Mental Health to local entities.

Members of the committee, which should be chaired by the Director of MRDD, should include representatives from provider organizations, SB 40 Boards, family members or guardians of a person with a disability, self-advocates, Regional Center employees, Missouri Protection and Advocacy Services, and the Missouri Planning Council. A final report with recommendations should be submitted to the Mental Health Commission and the Lieutenant Governor by May 1, 2007. The feasibility report should include a study of economic impact, timelines, and strategies for implementation if so recommended, along with proposed legislation if needed.

JUSTIFICATION: The needs of people with developmental disabilities are best determined and met at the local level with input from individuals who need

services, their families and service providers. The role of the Department of Mental Health can be clarified to assure quality of services and provide oversight, monitoring, and accountability of community providers.

Missourians would benefit from a community-based system of contracted organizations that shall determine and be held accountable for the most appropriate means to deliver a system of supports and services to people with developmental disabilities when services are needed. Policy for this system should be developed with the meaningful participation and input from people with developmental disabilities, family members, community service providers, and other stakeholders. Consumer involvement will help assure that there are opportunities for real choices. They understand that inclusion in the community will result in acceptance by the community, thereby reducing the need for specialized, segregated services.

The committee shall evaluate for each region of the state whether or not the community providers can and are willing to provide the specialized intense care required by severely physically and mentally handicapped individuals, specifically persons in the habilitation centers.

A localized system encourages partnerships between consumers, families, and other community resources; facilitates the delivery of cost efficient and effective individualized services; and, establishes a system with greater accountability and transparency that will help ensure that people with developmental disabilities are safe from any abuse or neglect.

Families, guardians, and individuals with developmental disabilities must be allowed a significant role at all stages in Departmental planning. They are uniquely qualified to assess quality of care and have a contribution to make to the creation and implementation of policy.

This recommendation has some commonality with one of the recommendations within the Mental Health Commission's Report.

IMPLEMENTATION: Department initiative.

25. The Department of Mental Health shall prepare an annual report to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.

JUSTIFICATION: The safety of consumers served under the auspices of the Department of Mental Health must be ensured. It is a basic right. The current system has been improved since 2005, but can be made more responsive and effective. Oversight is critical to ensure appropriate implementation of the recommended changes so that the faith between Missouri citizens and Missouri government is preserved.

IMPLEMENTATION: Department initiative.

Conclusion

Since the 1950s, philosophies regarding the care and treatment of persons with mental illness, mental retardation, and developmental disabilities have changed dramatically. The development of a wide range of psychotropic drugs has enabled many persons with mental illness to live in communities. More active care and support of persons with disabilities has enabled many to live independently or in homelike settings outside of institutions. Deinstitutionalization has been steady, with institutional populations declining by as much as 90 percent and psychiatric hospitals changing from long-term placement facilities to acute treatment centers.

Systems of oversight have not kept pace with these changes, and consumer safety has suffered as a result. A dynamic tension exists between personal safety and personal choice. We must embrace this challenge and recognize the importance of a continuum. Choice may begin with safety and progress to accomplishment.

The Task Force offers these recommendations for change so that:

- All citizens in the mental health system will have the opportunity to develop their capabilities to the fullest extent possible.

- The emphasis is on a working partnership with the individual, family, and community to provide a well-planned continuum of quality services.

- Services will be planned according to self-directed choices and needs. This will be accomplished by maximizing state/community services and by utilizing the natural supports in the individual's life. Service delivery will be done in a collaborative fashion.

- Staff will participate in state-of-the-art training and be provided the necessary supports to successfully work with individuals and their families.

Implementation of these recommendations will move us toward consumer safety and toward actualization of our vision:

"Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse."

Mental Health Task Force Members

Respectfully submitted:

Peter D. Kinder, Lieutenant Governor
Chair

Ron Dittemore, Ed.D.,
Interim Director
Department of Mental Health

Mark James, Director
Department of Public Safety

Julia Eckstein, Director
Department of Health & Senior Services

Steve Renne, Deputy Director
Department of Social Services

Natalie Woods, President
Nevada Habilitation Center Family Assoc.

Wendy Buehler, President
Life Skills Foundation, St. Louis

Terry Mackey, President
Arthur Center, Mexico

Appendices

APPENDIX A

Biographies of Task Force Members

Peter D. Kinder, Lieutenant Governor, Chair

Peter D. Kinder was elected Missouri's 46th Lieutenant Governor on November 2, 2004. As Lieutenant Governor, he serves as the official Senior Advocate for Missouri. While in the Missouri Senate, he sponsored and passed the Elderly Protection Act in 2003, which increased the penalties for elder abuse crimes. In his current capacity, Lieutenant Governor Kinder continues to work to protect Missouri's most vulnerable citizens. Lieutenant Governor Kinder was appointed as a co-chair of the Missouri Mental Health Task Force by Governor Matt Blunt on June 15, 2006.

Ron Dittemore, Ed.D., Interim Director, Department of Mental Health, Co-Chair

Dr. Dittemore was appointed as Interim Director for the Missouri Department of Mental Health by the Missouri Mental Health Commission on July 1, 2006. He replaced retired Director Dorn Schuffman. Each year, the Department of Mental Health serves over 150,000 Missourians impacted by mental illness, developmental disabilities, and substance abuse. Dr. Dittemore worked in the Department for 33 years, retiring in 1999 as Superintendent of Northwest Missouri Psychiatric Rehabilitation Center in St. Joseph. He was appointed to the Mental Health Commission in June 2005 by Governor Matt Blunt.

Wendy Buehler, President, Life Skills, St. Louis

A graduate of Fontbonne College, Ms. Buehler began her career as a special education teacher and joined Life Skills in 1981, working directly with people with disabilities. Ms. Buehler has held numerous positions with Life Skills over the past 25 years and was named President of the organization in 1997. Life Skills was established in 1964 and serves more than 1400 people across four counties and employs nearly 600 staff. Life Skills is known for quality and innovative services and helps people with disabilities to live on their own and to find and keep meaningful jobs. Ms. Buehler is the past president of the Missouri Association of Rehabilitation Facilities and is a 2003 graduate of the Leadership St. Louis program. Ms. Buehler resides in St. Louis.

Julia M. Eckstein, Director, Department of Health and Senior Services

Julia Eckstein was appointed by Governor Matt Blunt to serve as Director of the Missouri Department of Health and Senior Services on February 15, 2005. As Director, Ms. Eckstein oversees an agency responsible for the state's public health activities, including disease prevention, bioterrorism and other emergency health threats, promoting healthy behaviors and preventing chronic diseases, environmental health and infant and children's health. She also

oversees programs that provide protection and services for older Missourians as well as programs that protect the public by licensing and inspecting hospitals, child care facilities and long-term care facilities.

Mark James, Director, Department of Public Safety

Mark James, Director of the Missouri Department of Public Safety, has over 28 years of experience in protecting Missourians. For nine years James worked with the Missouri State Highway Patrol before starting a 19-year tenure with the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF). James was the special agent in charge of the ATF Bureau for the Kansas City Division, which encompassed a four-state area. Responsible for many safety initiatives and intelligence efforts, James has protected Missourians by enlisting the help of police departments throughout Missouri, Kansas, Nebraska and Iowa. Unafraid to review and rebuild existing departmental infrastructure, James has been responsible for overhauling ATF's intelligence function and designing the MSHP's first criminal intelligence unit. James received a bachelor of science in criminal justice and administration from Central Missouri State University and a master of science in strategic intelligence from the Joint Military Intelligence College of the Department of Defense.

Terry Mackey, President, Arthur Center, Mexico

Terry Mackey is president of Arthur Center, a community mental health center located in Mexico, Missouri, that provides psychiatric services to persons in Audrain, Callaway, Montgomery, Pike, Ralls, and Monroe counties. Mackey is a parent of three sons with developmental disabilities and serves as Chairperson of the Missouri Planning Council for Developmental Disabilities. He and his wife, Cindy, have been married 29 years and are both Licensed Clinical Social Workers. His education includes a B.S. in Business Administration from Columbia College and a Masters of Social Work from the University of Missouri-Columbia. In addition, he serves as Secretary/Treasurer of Missouri Coalition of Community Mental Health Centers and is a board member of United Credit Union in Mexico.

Steve Renne, Deputy Director, Department of Social Services

Steven E. Renne served as Interim Director for the Department of Social Services (DSS) until October 16, 2006. He has been with the Department of Social Services since 1989. DSS is the umbrella agency consisting of the Children's Division, Family Support Division, Division of Medical Services, Division of Youth Services and four support divisions. Steve has 27 years of experience in state government, including the State Auditor's Office, Missouri House of Representatives, and the Department of Social Services.

Natalie Woods, President, Nevada Habilitation Center Family Support Association

Mrs. Woods is the legal guardian for her younger sister who has mental retardation, cerebral palsy, behavioral disorders, and numerous complex medical conditions. Mrs. Woods has been a proactive mental health advocate for the past several years, specifically for those with mental retardation and developmental disabilities. Mrs. Woods works closely with many families and individuals across Missouri and is dedicated to advocating on behalf of individuals with developmental disabilities who are unable to represent themselves.

APPENDIX B

Memoranda of Understanding

Missouri Department of Health and Senior Services
Division of Regulation and Licensure
Memorandum of Understanding

This Memorandum of Understanding (MOU) is between the Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Section for Long-Term Care (SLTC) and the Department of Mental Health (DMH).

1.0 Purpose

To comply with the action items identified by the Governor's interagency taskforce on DMH investigations, by monitoring certain investigations conducted by DMH at the 9 DMH habilitation centers identified in 4.0 below.

2.0 Timeframe

Activities to be performed under the requirements of this MOU begin at 12:00 a.m., Monday, June 26, 2006. Complaints received by DMH between 12:00 a.m., Monday, June 26, 2006 and 12:00 a.m. on Friday, August 25, 2006 will be monitored by SLTC. All monitoring activities and the writing and review of the SLTC final report will be completed by close of business on Friday, September 15, 2006.

3.0 Scope

SLTC staff will monitor the DMH investigations of complaints involving abuse, neglect, and/or fatalities at all of the nine habilitation centers. Such monitoring will not be focused on the actions or procedures of the facilities involved, but will examine the appropriateness, timeliness, and thoroughness of the investigations conducted by the DMH staff assigned to the investigations.

4.0 Facilities Covered

Activities will be performed related only to complaints received regarding the following state operated habilitation facilities:

Bellefontaine Habilitation Center, St. Louis, MO
Higginsville Habilitation Center, Higginsville, MO
Marshall Habilitation Center, Marshall, MO
Nevada Habilitation Center, Nevada, MO
Northwest Habilitation Center, Overland, MO
SEMORS – Poplar Bluff Site, Poplar Bluff, MO
SEMORS – Sikeston Site, Sikeston, MO
South County Habilitation Center, St. Louis, MO
St. Charles Habilitation Center, St. Charles, MO

5.0 Activities to be Performed by SLTC

1. Monitoring procedures

   The DMH investigations of all complaints at any of the nine habilitation centers will be monitored by SLTC staff through on-site observations and review of documents.

   An evaluation checklist will be used by SLTC staff to evaluate each investigation. This checklist will rely on the requirements identified in the formal procedures documents prepared by the DMH investigations unit.

2. Feedback and evaluation

   An evaluation checklist will be completed by the SLTC staff monitoring each investigation, and will form the basis for a final report to be provided to DMH by September 15, 2006.

   The final report will include summary information about the quality of the DMH investigations, areas in which stated procedures and policies were not followed, and recommendations for improvements.

3. Monitoring Limitations

   SLTC monitoring staff will not provide consultation or training during the monitoring visit. If at any time SLTC staff observe a potential immediate jeopardy situation that is not being addressed by the facility or the DMH investigator, or SLTC and DMH staff arrive at differing conclusions, SLTC staff will immediately contact the SLTC Central Office contact for their determination of further action or involvement.

   The SLTC Central Office contact person will contact the DMH central office contact.

4. Cost Documentation and Limitations

   SLTC will document and provide to DMH a record of all expenses incurred—including the cost for salaries (regular and overtime) and travel—by SLTC to fulfill the requirements of this MOU.

   The monitoring of DMH investigation activities by SLTC staff is outside the scope of SLTC's normal duties and is also outside the scope of the DHSS agreement with the Centers for Medicare and Medicaid Services for survey and certification activities, therefore the costs associated with these activities cannot be submitted as a claim for Medicaid funds.

6.0 DMH Actions

1. DMH will provide funding to cover the following:

a. Salaries for SLTC staff involved in monitoring activities, including any overtime incurred
b. Travel expenses related to monitoring activities; to include mileage, meals, and overnight accommodations, when necessary

2. DMH will provide SLTC with all necessary SAM II coding needed in order to directly charge DMH appropriations for all costs incurred. This will include an LDPR that will be used for coding both regular and overtime hours and the appropriate coding for travel expenses reported on SLTC staff's monthly expense reports.

3. DMH will provide all needed documents and reports related to monitoring activities to SLTC on a timely basis, including any information needed prior to the commencement of any monitoring

4. DMH will comply with the established protocol for notifying SLTC of complaints

5. DMH investigation staff will cooperate fully with SLTC staff assigned to each monitoring activity.

Julia M. Eckstein
Director
Department of Health and Senior Services

6/28/06
Date

Dorn Schuffman
Director
Department of Mental Health

6/28/06
Date

MEMORANDUM OF UNDERSTANDING
BETWEEN
MISSOURI DEPARTMENT OF MENTAL HEALTH
AND
MISSOURI DEPARTMENT OF SOCIAL SERVICES

This Memorandum of Understanding is entered into on the 3rd day of April, 2006 ("Effective Date") between the Missouri Department of Social Services ("DSS") and the Missouri Department of Mental Health ("DMH"). The parties enter into this Memorandum of Understanding for the purpose of enhancing DSS employee background checks by allowing DSS access to the DMH Employment Disqualification Registry ("EDR") as allowed pursuant to Sections 610.032 and 610.120.1 of the Missouri Revised Statutes, and any other applicable statutes.

WHEREAS, DSS conducts background checks regarding employees pursuant to DSS Policy 2-107.

WHEREAS, DMH maintains an employment disqualification registry pursuant to section 630.170, RSMo containing the names of individuals disqualified from holding any position in any public or private facility or day program operated, funded or licensed by the department or in any mental health facility or mental health program in which people are admitted on a voluntary or involuntary basis or are civilly detained pursuant to chapter 632, RSMo.

WHEREAS, DSS and DMH agree to cooperatively work to ensure disqualified persons are not employed to work with persons with disability or children.

WHEREAS, DSS is subject to restrictions regarding the disclosure of information made confidential pursuant to state law, and

WHEREAS, DSS and DMH are executive agencies of the State of Missouri.

NOW, THEREFORE, the parties agree as follows:

Section I. **Scope of the Permitted Disclosures**

1. DMH agrees to provide to DSS a computer generated text file containing the following information for all individuals on the DMH EDR:

(a) First name of disqualified person;

(b) Last name of disqualified person;

(c) Middle Name of disqualified person (if available);

(d) Social Security number of disqualified person;

(e) Indicator showing whether or not the name is an alias (A for Alias, P for Primary);

(f) Registry Identification Number for the primary name of disqualified person;

(g) Registry Identification Number for the alias name of disqualified person (if an alias exists);

(h) Gender of disqualified person;

(i) Date of Birth of disqualified person;

(j) Creation Date (the date the person was added to the EDR)

2. The generated text file shall be made available to DSS within one working day subsequent to the entry of the disqualified person to the DMH EDR.

3. DSS agrees to set up limited access to the information identified in Section I for the Deputy Director for Investigations and designated investigators.

4. The DSS Deputy Director for Investigations and designated investigators may contact the DMH EDR Director to request and obtain charge information, determination letters, and other relevant information for persons on the EDR.

Section II. Review and Amendment

1. The terms of this Memorandum of Understanding may be reviewed and modified as necessary on an annual basis and shall be automatically extended unless either party terminates this agreement.

2. Any modification or extensions shall be accomplished by a formal amendment to the Memorandum of Understanding signed by both parties.

Section III. Effective Date and Term

1. This Memorandum of Understanding begins on the Effective Date and remains in effect until terminated by either party pursuant to Section IV of this agreement.

Section IV. Termination

1. Either party may terminate this Memorandum of Understanding by giving the other party not less than thirty (30) days written notice of termination.

Section V. Material Breach

1. If either DSS or DMH become aware of any practice by the other which may constitute a material breach of any of the provisions of this Memorandum of Understanding or a violation of law pertaining to the disclosure or use of the information contained on the EDR, it will notify the other department within two (2) business days and discuss possible remedial action. In the event the parties are unable to agree upon remedial action, the party discovering such material breach may terminate this Memorandum of Understanding without penalty, immediately upon giving written notice to the other.

Section VI. Miscellaneous

1. Disclaimer. DSS is solely responsible for its decisions regarding safeguarding the confidentiality, use, and disclosure of information contained on the EDR.

For DSS

4/3/06
Date

For DMH

4/10/06
Date

APPENDIX C

Excerpts from the Missouri Mental Health Commission Report to the Governor

Recommendations for Building a Safer System

1. Accreditation of all habilitation centers should be pursued immediately.
2. Information management methods must be implemented to rapidly and effectively track critical data on abuse, neglect and safety information.
3. There must be a proper balance of investigative responsibility that incorporates external resources (such as law enforcement, outside consultants, or other Missouri departments, etc.) to supplement internal investigation functions.
4. Every DMH facility and residential service provider must be held responsible for instituting and monitoring a fail-safe methodology for timely reporting of crucial incidents to Central Office. Such methods should include clear duality in the pathways through which this critical information flows.
5. The Department of Mental Health must separate the internal authority for investigative procedures from its legal counsel.
6. The Department of Mental Health should aggressively support and facilitate the creation of legislation to allow for non-confidential information regarding abuse and neglect to be made public.
7. As a matter of policy, a fixed proportion of facility operating expenses should be set aside for the exclusive purpose of supporting continuing education and training of staff.
8. A system needs to be implemented by which supervisors are consistently held responsible for the actions of staff under their supervisory authority. Supervisors must also be accountable for information gathered by ombudsman related to the quality of service, their professionalism and the appropriateness of their human interactions with co-workers and clients.
9. Consumers, families and their advocates should have access to both an internal and external designated ombudsman whose responsibility is to independently collect complaints and reports of incidents, to preliminarily investigate those reports, and to provide summaries of its findings to both the executive team of the Department of Mental Health and to Missouri Protection and Advocacy.
10. All deaths in DMH-funded facilities should be reported to a coroner or medical examiner.

11. The Department of Mental Health must explore multiple options for external review and involvement of family and natural supports in all aspects of service delivery.

12. The relationship between regional centers and community service providers must be clarified, and their work integrated to achieve efficiency and improve both accountability and quality of care.

13. Establish minimum requirements for facility directors to be present during night and weekend shifts in their respective facilities, as well as minimum requirements for unannounced site visits to all facilities.

14. Clear expectations must be maintained at all times about which incidents are reported to police, and surveillance of reporting to police (via cross-referencing of incident information and police reporting) must be maintained by DMH Central Office.

15. The Department of Mental Health and the Governor must make a clear and unequivocal commitment to providing a continuum of facility and community-based services that afford real choices to all Missourians who require DMH services.

16. When funding is inadequate to provide service, the scope of service must be reduced, the public informed, and the decisions about service reduction/prioritization should rest with the Director of the Department.

17. The Mental Health Commission strongly supports flexible funding options, including the full implementation of Olmstead, which mandates that funding follow the consumer, allows their choice of support providers, including allowing families to care for their loved ones in their own homes utilizing natural supports.

18. The Department Director must augment the executive team in such a way that it improves inter-divisional communications, with adequate staffing to carry out the overarching mission of the Department of Mental Health.

19. Video camera surveillance should be strongly considered for all DMH facilities.

20. The Department should facilitate the development of drug and mental health courts which serve as a diversion from incarceration and have begun to successfully combine treatment with rehabilitation.

21. Crisis Intervention Training (CIT) should be further expanded in the state as a method to prevent persons with mental illness from being inappropriately placed in the criminal justice system.

22. The Department must develop a comprehensive plan, including adequate staffing, for addressing the unique mental health needs of aging DMH clients.

23. The DMH budget must stabilize, recover (to compensate for relative losses suffered over the past decade), and be further supplemented to implement these recommendations.

The report can be viewed in its entirety at www.dmh.mo.gov

APPENDIX D

Summary of Public testimony

Recommendations and consolidation from oral and written public testimony that has come to the Task Force via the hearings, the web site, and written public comments. The following suggestions have come directly from public testimony and have been grouped according to similarity and patterns. The intent is to provide you with the opportunity to have simply stated input from Missourians in response to our request for their ideas. This list includes suggestions regarding abuse and neglect as well as general recommendations on the Department of Mental Health as a whole, state government in general, etc. Please note that much of the language contained in the numbered suggestions comes directly from the words used by the person testifying. The passion is clear. These are the folks who took the time to share their thoughts with this Task Force. Summary:

1. **Staffing.** Across the board, the area of staffing was mentioned by most individuals who testified. They believe direct care staff are doing a great job for the most part, but are not fully appreciated. Several commented that staff turnover was a significant problem and provided ways to impact retention of employees. Families articulated gratitude for caregivers who were able to give loved ones what they themselves had been unable to give. Low salaries and a lack of benefits (especially access to health care) were mentioned as factors. Budget cuts over the years have reduced the number of FTEs available for direct care, possibly setting up unsafe levels of staffing in some instances. One consequence of this is mandatory overtime in some facilities.
    - 1.1 Focus on direct care staff that does a remarkable job considering all they deal with in the course of an eight hour shift. Salaries and benefits need to be increased at both state-operated and community-based providers of residential services.
    - 1.2 Reduce the size of caseloads for Regional Center staff so they can be effective in their jobs, visit clients as they are supposed to, etc.
    - 1.3 Do away with all mandatory overtime. Tired staff that have been held over for another shift are more likely to be impatient, unkind and abusive to residents.
    - 1.4 Consider instituting a dress code for employees and providing health care apparel for direct care staff like developmental aides. Ban the use of cell phones in the work place except for supervisors. Direct care staff especially ought not to have access to them while on duty.
    - 1.5 Hold each employee accountable for their behavior choices; nothing should be hidden or excused.
    - 1.6 Staff supervision needs to be improved, especially within the services delivered by community based organizations. Consider reinstating DA2's supervisory authority.

1.7 The expectations for case managers and QA staff are overwhelming. The increase in paper work makes the job impossible to be completed in a 40 hour work week.

1.8 Restore full-time directors for the Regional Centers rather than consolidating positions as they are now.

2. **Staff Recruitment, Orientation and Training.** Testimony from the public at the hearings, especially from parents and guardians, placed a real emphasis on the need for a range of staff development. Several expressed the opinion that in the past, significant resources were directed toward training. With budget cuts over the past ten years, parents feel most training has been discontinued making it impossible for staff to keep up-to-date on evidence based practices. Staff themselves cited incomplete background checks, hurried training that is not reinforced after work has commenced and a discrepancy between expectations and actual work once the job has begun. Several staff offered the opinion that some individuals ought never to have been hired; they wonder if a screening test could be used to make sure an individual's personality is compatible with this type of work and with these populations. Connecticut requires that both state and provider staff receive on-the-job training within 30 days of being hired, and must be retrained in most areas every 2 years.

   2.1 Ensure that staff working with consumers have passion and compassion.

   2.2 Train staff and parents to recognize signs of abuse and neglect.

   2.3 Establish an incentive program for staff to reinforce retention; develop a relationship with the College of Direct Support to create a career ladder for direct care staff. (This means making a variety of training courses available to staff *on line*.)

   2.4 Provide statewide CIT (Crisis Intervention Team) training. Increase training for direct care staff to include anger management and crisis management. Training needs to be restored and re-visited after initial certification is passed.

   2.5 Orientation of new direct care employees ought to involve direct care staff so expectations in the workplace can be as realistic as possible regarding conditions and residents' behaviors.

   2.6 Involve parents in training direct care staff.

   2.7 DMH could create partnerships with other agencies for training as a way to share the expense. Change new employee orientation to provide every new employee with hands on experience with DMH consumers - from CPS, ADA and MRDD - for a first hand understanding of what's driving our work.

   2.8 Our DMH direct care staff needs more mature, experienced workers. We need to address the use of profanity in the workplace. Some MRDD residents earn more than their caregiver staff. HR personnel must maintain confidentiality.

   2.9 Provide training so that every Regional Center would have a case manager prepared to work with individuals with traumatic brain injury.

   2.10 Recruiting, interviewing and hiring staff needs to be completed without showing favoritism and utilizing a consistent process.

2.11 Stress the need for professionalism and confidentiality with all staff especially techs and developmental aides.

3. **Hotline.** Having access to a hotline so that allegations of abuse and neglect could be made anonymously was also suggested. This would be similar to the hotline operated by DSS under child protective services. Parents and caregivers felt that initially the number of reports would increase once the potential for retaliation was diminished.
   3.1 Establish and promote a hotline which parents and others could call to report allegations of abuse and neglect anonymously without fear of retaliation.

4. **Investigations.** Safety for those vulnerable men, women, youth and children who receive direct services from DMH or services through a contracted provider remains the focus of the public input process. The heart of the task is to *prevent* abuse and neglect utilizing comprehensive strategies. Failing this, the goal is a quality, effective, appropriately funded response to allegations of abuse and neglect. Families expressed both satisfaction with the response process and frustration. The task is to build on the effectiveness currently in place, yet institute recommendations for improvement. Who does the investigation? Is every allegation investigated? Is every allegation handled in the same manner? How long should an investigation take? What is the role of Missouri Protection & Advocacy Services? It makes sense to examine the experience of other states in deciding how to manage this issue. Several opinions were expressed through the Task Force web site, as well as via oral public testimony at the hearings. Some testifying felt the Investigations Unit should be removed from DMH.
   4.1 No agency ought to monitor itself. Establish an independent agency to complete investigations of allegations of abuse and neglect.
   4.2 Develop some kind of rating system that would be available to the public relative to the number of allegations of abuse and neglect substantiated at that particular facility – something similar to the five star rating for hotels. Parents would look at that when making placement decisions.
   4.3 Include the investigation of deaths of children with disabilities in the DSS system of investigation and review.
   4.4 An in-house investigation ought to be completed when an allegation is made to avoid the whole issue of false accusations and the like.
   4.5 The recent changes in the way investigations of allegations are conducted are perceived by some as having created a negative impact. Central Office staff and staff of sister agencies have sometimes been understood to be rude and have been unable to set the staff, alleged victim or perpetrator at ease to encourage conversation. This may ultimately discourage reporting. The style has been aggressive and some staff have come away from interviews feeling like criminals.
   4.6 Change the law so that abuse and neglect violations can be made public.

4.7 Support legislative changes that would eliminate the finding of “Neglect II” as it creates confusion and instills fear. It can be interpreted so broadly that virtually any action could be interpreted to fall in this category.

4.8 The system as a whole must be culturally responsive while investigating abuse and neglect allegations.

4.9 Not every allegation carries the same weight. Each one must be reviewed, but there needs to be a system to help determine which investigations require the skill of a highly trained investigator and which ones can be handled in a simpler fashion. This must be clearly defined so that quality is maintained and the alleged victim is always protected appropriately.

4.10 Hire more investigators.

4.11 Contract with Missouri Protection & Advocacy Services to investigate abuse and neglect at state facilities; they should also review 15% of all investigations.

5. Quality of Care. There was a strong feeling that the budget cuts over the last ten years have been so extensive that the Department of Mental Health is not able to provide the basic services needed by persons with alcohol and drug abuse, mental retardation/developmental disabilities and mental illness. Some even categorized this as the Department of Mental Health is being abused and neglected and left unable to fulfill its legislative mandate. For some, there is a great sense that the continuum of care available through combined state-operated and state-contracted services is competitive rather than complementary.

5.1 Improve the quality of programming by requiring independent accreditation by national organizations (such as CARF) for both state operated and community-based programs.

5.2 Support the funding of all programs receiving the same “base” Medicaid waiver reimbursement regardless of size or location.

5.3 Increase funding for “in home” services which would prevent out of home placements.

5.4 Look specifically at Iowa’s IFA programs; programming that supports independence developed by Midland Michigan, Seattle, Washington and Ohio. Expand the Independence Plus program.

5.5 There is a lack of standards for mental health clients who reside in behavioral units of nursing homes.

5.6 DMH has too many rules now and is moving away from a person-centered approach. There is a focus on “who will get the blame if something goes wrong?” and this discourages calculated risk taking which kindles zest for living.

5.7 The Regional Center system within MRDD is so bureaucratic at times and focused on micromanagement that the concept of person centered planning has been lost. Client choice is ignored in favor of utilization review committee decisions. Some Service Coordinators do not know their clients. Some Regional Center nurses interfere in the lives of clients to their detriment. Provider staff are sometimes held to a higher standard than Regional Center staff.

5.8 Approach the National Academy of Arbitrators to appoint an agreed upon panel of professional fact finders to thoroughly review DMH and provide an analysis of the quality of programming.
5.9 Develop a system for parent feedback on providers that can be accessed on line – like e-bay has. Make it user friendly.
5.10 Assign an advocate to every person admitted to a state psychiatric facility especially if they are on strong medications.
5.11 The move to private placements has increased danger to consumers because there is inadequate planning and assessment regarding the most appropriate placement.
5.12 Discontinue all institutional care in Missouri.
5.13 When we are already short of staff in the hab centers, do not take in new admissions until we can staff to meet their needs.

6. Prevention. In general, it is more effective to focus on **preventing** abuse and neglect rather than simply trying to fix the problem after the abuse occurs. The framework for preventing abuse and neglect involves effecting cultural change both within the state-operated facilities and the community-based services by creating caring employeeswho feel supported in their jobs, possess the skills and tools necessary to work with the consumers, are compensated fairly and have a passion for their work which is displayed regularly. The other piece of cultural change must be reflected in the environment across our state and played out in our communities. There must be support for policy change, acceptance and welcoming of those with differences into our midst and a willingness to ensure adequate funding for necessary services. While the Department prepares for these important, intangible changes, some improvement is possible through the implementation of specific exterior changes. “An affirmative requirement that the facility take prompt and consistent disciplinary action when a charge of abuse/neglect is confirmed by the investigator is prevention that can be reflected in statutes.”

6.1 Provide training for individuals with disabilities to be self advocates; they need to know the signs of perpetrators and how to self report.
6.2 Increase involvement in sports to a significant degree as a way to manage client behavior. The Special Olympics model is successful and could be utilized.
6.3 Address emergency situations and enforce a clear chain of command for this time.
6.4 Make necessary physical repairs to residential facilities to minimize consumer risk for injury. Conduct a safety/maintenance check on equipment in use at both state-operated and state-contracted facilities to determine if it is faulty. This would include hot water valves, sidewalk cracks, furnaces, stoves and the like. Results ought to be documented and verified.
6.5 Install and use video cameras as a deterrent to abuse and neglect in all facilities.
6.6 Please consult parents as programmatic decisions are made; they are the most accurate source of “what works” for the child/person with disabilities.

6.7 We need to use early intervention as a way to address mental health needs. Evidence based curriculum is effective.

6.8 Law enforcement personnel need training on how to manage individuals with disabilities. Provide education and training for law officers and prosecutors concerning abuse of persons with MI or MRDD.

6.9 Make arrangements to appoint a legal guardian for each consumer who needs one upon the 18th birthday. Encourage the creation of mental health courts throughout the state by working with individual judges.

6.10 DMH is missing the boat in working with families. If we did this well when kids were young we would reduce the need for DMH services later in life.

6.11 The Partners in Policymaking class is wonderful; increase its availability.

7. Budget/Funding Issues. It is clear that many decisions at DMH have been driven by budget cuts. The ramifications of the monetary reductions are far reaching and impact all areas of the Department. Many individuals commented on the need to fully fund the services needed by Missourians who qualify and need DMH services. The Department cannot do more with less and remain responsible. If there is less available, fewer services must likewise be available.

7.1 The current shortage of acute beds for severely mentally ill persons threatens safety within the community and within any program accepting them. Often these individuals are homeless, hang around in the community as a result and become involved in criminal activity.

7.2 There are not enough psychiatrists at the Mid-Missouri hospital and the workload is distributed unevenly among the one who are there.

7.3 In order for informed choice to be valid for consumers, a continuum of care services must be available. This means having the habilitation services available as a choice for those seeking that structure. Many parents made the comment, “One size does NOT fit all!”

7.4 Services for those with serious, persistent mental illness, usually in conjunction with dual diagnosis, must be available. This overlaps and becomes an abuse/neglect issue when the client becomes violent and hurts other staff and/or volunteers. Three Public Administrators were present to emphasize this reality, as did one parent.

7.5 We must address the severe under-funding of mental health services.

7.6 Create a Task Force to study the concept of “the money follows the person.”

7.7 Individuals with mental illness who reside in a residential care facility are forced to pay co pays. At $1 per prescription, this eats into their $25 per month for personal care items.

7.8 Establish a policy requiring a study on cost effectiveness before closing or downsizing state facilities.

7.9 Women with chronic, pervasive mental health diagnoses who have limited or no access to state funded services are straining the already limited resources of shelters for domestic violence. Following the Medicaid cuts, clients who self-report having these diagnoses doubled. They are also having difficulty obtaining necessary mental health medications that were previously funded through Medicaid.

7.10 Follow up on audit recommendations given to Regional Centers and providers.

8. **New Programming.** Some new programming has the potential to impact the system as well. In general, the implementation of new services should be based on evidence based information. The better the system is in general, the greater the potential to prevent abuse and neglect.
   - 8.1 Establish a “crisis house” that would be available if a person with mental illness/behavioral concerns residing in a community placement encountered difficulties and it was determined that a respite or time out period would be in the best interests of everyone.
   - 8.2 Prevent depression in our elders by establishing day care centers in conjunction with elderly housing so children and elders can work together in mutually beneficial ways.
   - 8.3 It is difficult for persons on psychotropic medication to find a psychiatrist to dispense monthly prescriptions for their meds given the great shortage of psychiatrists. One avenue of relief could be to adopt standards of knowledge and practice for doctoral level psychologists to be able to write prescriptions (as can physician assistants, nurse practitioners) under the supervision of a psychiatrist.
   - 8.4 Partner with the Department of Health and Senior Services to encourage medical professionals to specialize in the health care of persons with MI and/or MRDD.
   - 8.5 Missouri needs to develop residential resources for youth aged 17-22 who are in the process of transition to adulthood. They ought not to be housed with older populations.
   - 8.6 As we saw in following Hurricane Katrina, it was individuals with disabilities, the frail elderly, and the vulnerable who were left behind. We need to develop a plan for Missouri that does not permit this to occur in the face of a major disaster in this state.
   - 8.7 Develop a “grass roots” advocacy system with regular meetings. The culture of DMH needs to be enhanced by openness and renewal.
   - 8.8 The data system needs to be upgraded so that information is available to aid decision making.
   - 8.9 Drop the Extended Hours trial program at Marshall until we increase staff.

Input to our work from our constituents is vital. Several suggestions were made for system redesign in general, not specific to reforming the process for increasing safety for consumers. We will keep these on hand to refer to as we work through the Transformation process in the future.

Additional Suggestions for Change

1. Be cautious in hiring a new Director for DMH; make sure his/her philosophy is consistent with the intent of these proposed changes. Hire a person who is client-oriented.
2. Use the programming at the Higginsville Habilitation Center as a model for others across the state.
3. The forensic monitoring section is not working well; need a place/system to deal with pedophiles. There are many staff positions that are available but not filled due to the amount of funding. When contracted staff are utilized, often the result is high turnover and lack of continuity of care/professionals.
4. Lobby for individuals with disabilities to receive an adjustment for cost of living; increase their $30 per month living "allowance."
5. The bureaucracy is too complex for those with mental illness to negotiate.
6. Redesign DMH from the top down.
7. DMH's Division of MRDD is biased against the continuum of care that includes the habilitation centers; this needs to be changed. The plan to close the habilitation centers disrupts the safety net that needs to exist for difficult situations when community safety is a risk.
8. DMH's distribution of dollars has increased tension between the hab centers and community based programming.
9. Do away with the Facility Operations Team and the Columbus Group. Lines of authority are now quite muddled. Change new employee orientation to provide every new employee with hands on experience with DMH consumers – from CPS, ADA and MRDD - for a first hand understanding of what's driving our work.
10. Jails have become major providers of mental health services – a sure sign that our system is not working. Reduce appropriations for penal institutions.
11. Eliminate tax credits for corporations.
12. Check and reduce government spending in the Executive Branch for parties.
13. Support research into the nutritional basis for mental illness.
14. With three different Divisions, DMH presents a fragmented system with no sense of common vision.
15. I'm scared about losing services. My son's teeth didn't stop hurting just because he turned 19 and Medicaid will no longer cover dental care. I don't know which services will be discontinued next and I have no financial safety net as a widow unable to work.
16. We are happy with the way things are going here and hope you won't change the whole system because of issues in a large city like St. Louis.
17. MRDD and MI are diseases as surely as cancer; the insurance industry ought to have greater responsibility for treatment than is currently enforced.
18. The 96 hour hold law needs to be changed in Missouri; judges sometimes act on false information.
19. New hires must work 4 weeks before seeing the first paycheck; reduce that to two weeks to be in keeping with other employers.
20. Review the NAMI report card for Missouri to be pointed in other areas for improvement.
21. Enable SB 40 Boards to contract with for-profit agencies.
22. Any time a policy change is made that is expected to be followed, it should be issued in writing and implemented consistently.

APPENDIX E

Recommendations From Other State Agencies

DMH/DHSS Investigation Monitoring Report
September 15, 2006

Situation: The Department of Health and Senior Services' (DHSS) Section for Long Term Care (SLTC) executed a Memorandum of Understanding with the Department of Mental Health (DMH) to monitor the abuse and neglect investigations completed by the DMH Investigations Unit at all nine state operated habilitation centers. The DHSS review was in response to the action items identified by the Governor's Interagency Task Force on Department of Mental Health investigations.

The focus of the DHSS monitoring was to examine the appropriateness, timeliness, and thoroughness of the investigations conducted by the DMH staff assigned to the investigations. The focus of the monitoring was not to review the clinical actions or procedures of the habilitation centers involved.

Background: The Investigation Unit in the Office of General Counsel (OGC) of DMH is notified of allegations of abuse and neglect through the use of an Investigation Request Form. All requests for investigation of abuse, neglect, or misuse of funds/property are reported by the superintendents of the various facilities. Based on current procedures, the superintendent of the habilitation center first determines if there is "reasonable suspicion" that abuse or neglect has occurred and whether an investigation is warranted.

After the Investigation Request Form is submitted to OGC, it is evaluated by a senior staff person at OGC for completeness and whether the criteria for "reasonable suspicion" have been met. From OGC, the request is either referred to the regional investigation unit for assignment, or the request for an investigation is denied.

Investigators are not allowed to deviate from the standard procedure in the procedure manual for the reporting of investigation needs. While conducting an investigation, an investigator is not authorized to accept any additional reports or requests from the facility where the investigation is proceeding. Therefore, even if a facility reports additional incidents to an investigator while the investigator is on site, the investigator is not permitted to add the additional circumstances to the ongoing investigation. Investigations are to remain focused on the specific allegation investigators are onsite to investigate.

This is distinguished from the situation when an SLTC employee investigates abuse, neglect or exploitation at a licensed facility. The SLTC employee not only investigates what was called in but also other incidents that come to light during the course of the investigation. Indeed, if a complaint at a licensed facility involves a particular type of resident/consumer (for example a diabetic), SLTC would "expand the sample" to include other diabetics at a facility to ensure that they were not the victim of the same type of abuse or neglect.

Assessment: During the 60-day monitoring timeframe, from June 26th to August 27th, 2006, SLTC monitored a total of 64 complaint investigations and examined the following key components of the DMH investigation process: Allegation Type; Case Assignment and Initiation; Fieldwork; Documentary Evidence; Physical Evidence; Interviews; Report Format; Notification Requirements; and Report and Statement to Determiner.

The DHSS assessment indicated strengths and concerns in the following areas:

- Case assignment and required prior notification to facility
- DMH investigation assignments are made based on workload and experience of the investigators.
- All investigators, within 24 hours of assignment, must contact the involved facility and supervising facility to give notice of the assignment, request relevant documentation and provide the facility with any instructions regarding the scene of the incident or evidence securing.
- During the 60-day monitoring, the investigation contacts with involved facilities were initiated within 24 hours of the investigators notification 78% of the time (50 out of 64 opportunities).

Concern: Unannounced onsite initiation of investigations is not allowed without special permission. The investigator contact is to be made **prior** to going onsite for the investigation. Investigators must have supervisor approval to arrive at the facility prior to verbal contact. This is distinguished from investigations (and inspections) conducted by SLTC of licensed facilities. In those cases, SLTC's visits are never announced in advance.

Fieldwork

Fieldwork is defined as the DMH investigator's departure from his/her work site or home to travel to the incident location or the facility providing services and the process of gathering evidence at the site. The time period for commencing fieldwork depends on the level of priority assignment to the case. The time is mandatory and not a guideline. This is in addition to the 24-hour contact as set out above as required in all case priorities.

The Investigation Unit's Procedure manual showed all ICF/MR cases are Priority 1-Critical. In Priority 1 cases, fieldwork (travel to the site) and contact with the facility to request documents, other evidence and other matters in preparation for the site visit shall begin immediately upon the assignment of the case.

Priority 1 cases include death with reasonable suspicion of abuse or neglect including those receiving residential services where there is a suspected suicide or accidental death such as drowning or choking. The procedure did not indicate there were any differences for consumers who are "certified for Medicaid" as compared to consumers who are not Medicaid certified.

Concern: SLTC review after the 1st week of monitoring noted that the calls regarding reports did not typically occur after 6:00 p.m. on a Friday and no calls were made over the

weekend. OGC staff stated reports may be faxed to the OGC over weekends; however, the approval for investigation and assignment of the case does not usually take place until Monday. The investigation time clock begins with the assignment and not with the request for an investigation. As a result of this practice, abuse and neglect investigations were, at times, not started until two or three days after the request was sent into DMH Central Office.

According to interviews with Unit Supervisors and the OGC staff, only cases involving a suspicious death are started immediately during evening hours or weekends. According to two of the supervisors, an estimated three or four calls in a year rise to the level requiring immediate investigation in their regions.

After joint discussions regarding the onsite requirements for Priority I complaints, the OGC changed their procedure manual designating all ICF/MR cases as Priority 2- High. In Priority 2 cases, fieldwork shall begin and contact with the facility shall occur within one working day after the assignment of the case. This includes complaints or events with reasonable suspicion of physical abuse, sexual abuse, or Class I Neglect.

The OGC changed procedures during the monitoring period, after questions were raised by SLTC regarding the process for initiating complaints within 24 hours. The change made more closely reflects OGC's actual practice of initiating investigations within one working day after the assignment of the case. DHSS cautioned the OGC to wait and evaluate their system at the end of the monitoring period when other recommendations would be available. However, OGC made this change to their procedures during the monitoring.

Concern: During the investigation of complaints at one regional office, the supervisor of the investigation units and investigators indicated to DHSS staff that the timeframes for completing investigations for certified consumers were different than those for non-certified consumers. As a result of this practice, consumers were treated differently based on their payment source -- Medicaid/Medicare versus other payment sources, resulting in a longer timeframe for the initiation and completion of the investigation for non-certified consumers.

Concern: Currently, DMH does not have a triage system in place other than the Priority levels. For instance, a consumer who did not receive one on one supervision from a staff person who left, while the consumer was sleeping, to obtain something to eat from the refrigerator, is treated with the same urgency and time requirements as a consumer who was physically abused. Also, information contained in the investigation report forms, often does not provide sufficient information to make a determination of priority. Investigation forms at times did not include basic information including the consumer, alleged perpetrator, possible injury or harm to the consumer, and/or correct dates and times.

Documentary Evidence

DMH investigators were well versed in what documentation to obtain from the habilitation center.

Concern: Information from the habilitation centers was not always complete, accurate, or readily available for investigators. This caused some inefficiency. One problematic area for the investigators was obtaining information from hospitals, including possible witness information and the ability to review the consumer's medical record for information.

Physical Evidence

During most investigations, the investigator would either draw a diagram of the area or obtain the facility's floor plan. Investigators collected and maintained evidence as outlined in the procedures manual. Photographs of injuries were either taken or obtained from the facility.

Interviews

DMH investigators were skilled interviewers, asked pertinent questions and interviewed the appropriate individuals 92% of the time. Investigators interviewed consumers, witnesses, reporters, alleged perpetrators and additional facility staff who may have important information regarding the investigation and followed the policies and procedures for interviewing persons related to the investigations.

DMH investigators indicated interviews are expected to be conducted at a day and time that accommodates facility staff (rather than the investigators). Typically interviews are scheduled based on facility staff work hours and days of work. Often investigations required frequent onsite visits to the facility on multiple days and the investigation/interview process continued for up to three days.

Concern: The practice of accommodating every party to an investigation often delayed the completion of interviews. Several times preliminary determinations were made without the completion of all interviews. Alleged perpetrators or other witnesses not appearing for scheduled interviews were problematic for investigations. This can be especially difficult if an immediate statement was not received from the persons who were placed on administrative leave. Also, during several investigations, accurate contact information for the staff placed on administrative absence was not available.

Report Format

Investigations and investigation reports are to be completed within a five-day timeframe. The report format is very detailed and thorough. Most investigations included the preparation of an "Investigative Report", Memorandums regarding the specific conclusion/finding of fact of the investigation, a Plan of Action (which may or may not have recommendations), and any report addendum.

Notification

During the DHSS monitoring of investigations, DMH followed their rules regarding the notification of the parent/guardian of consumers involved in investigations 86% of the time. The investigator left messages or spoke to the guardians over the phone and often the parents/guardians were additionally notified by mail.

Report and Statement to Determiner

An important aspect of the DMH investigation includes defining who the "determiner" is for the investigation results. The habilitation center's superintendent or interim superintendent is the determiner of the investigation. The superintendent has final say as to whether abuse or neglect occurred and whether there is sufficient information in the investigation report to support this. Therefore, it is conceivable that the investigator could indicate abuse or neglect occurred, the OGC could agree with this determination, but if the superintendent felt otherwise, the result of the investigation could be very different from what the investigator concluded.

Concern: DHSS questions whether a superintendent can always be objective enough to see the possible system failure and how the failed systems may have played a part in the occurrence of abuse, neglect, or misuse of funds.

Recommendations:

- DMH should review its policies and procedures and ensure that the health, safety, and welfare of all its consumers is the first and foremost priority of all of its employees including the investigators as well as the clinical staff—indeed all of the employees of the department.

  DMH complaint investigation procedures need to be evaluated for effectiveness and a system put into place whose primary role is to assist in the prevention and protection of consumers through the investigation of abuse, neglect and misuse of funds. The current investigation focus is more of a punitive system for employees/staff rather than a means to assist in the safety/well-being of consumers, ensuring quality of care and quality of life.

  The review should address the benefit of allowing investigators to accept additional cases of alleged abuse/neglect while at the facility to ensure protection of consumers.

  The review should include the benefit of allowing unannounced investigations.

- DMH should evaluate current procedures that allow a Center's superintendent to have a central role in the determination of whether an investigation needs to be referred to the Investigation unit and a central role in the determination whether the investigation supports an indication of abuse or neglect.

- DMH should review completed investigations and explore Root Cause Analysis for complaints and issues which are recurring

  Investigations based on DMH's current procedures focus on identifying individual actions and do not identify system failures or identify root causes of identified areas or systems in the habilitation centers.

- Root cause analysis should include:

- Examination of supervision levels and staffing: Interviews with the facility staff indicated they often work double shifts, working anywhere from 50-60 hours a week. Many of the workers expressed feeling tired and stressed by the end of their shifts.

- Identification of facility system failures. Current investigation complaint procedures do not include evaluating systems within the habilitation centers themselves and identifying system failure. Currently, investigations are limited to the individual's failure or actions and investigators do not routinely evaluate the habilitation centers' actions.

  Example: iiTS#36205 - Two staff were each charged with the misuse of consumer funds/property. During the investigation, it was discovered the staff persons had taken two consumers' money out of their accounts on August 8, 2006. By facility policy, the remaining funds and receipts should have been returned to the consumer trust by the end of the next working day after the date of the withdrawal. However, in this instance, the receipts were not returned until August 17, 2006. When asked about the facility policy, the investigator stated they are only to investigate the misuse of funds, not whether the habilitation center had followed its policy. If the habilitation center had followed its own policy, the misuse would have been discovered earlier, protecting the consumers from reoccurrence. The Plan of Action for the facility did not address the failure of the habilitation center to follow their own policy regarding the use of funds from the client trust.

  Example: iiTS#36243 - Two staff assisted a consumer to a doctor's appointment. The driver had to ask repeatedly to have someone assist her with the consumer to the appointment and stated she had not worked directly with the consumer since 1997. An agency staff person who was unfamiliar with the consumer assisted the driver in taking the consumer to his/her doctor's appointment. Review of the consumer's medical record showed it did not contain information regarding the consumer's tendency to unbuckle his/her own seatbelt and this information was not communicated to the staff persons accompanying him. However staff familiar with the consumer stated they had noticed him removing his belt before. The determination was to substantiate Class II neglect for the two staff persons, one for failure to ensure the consumer's belt was attached (although the staff verbally stated they saw it attached when securing his/her chair to the van - although one staff admitted she did not pull on it) and for one of the staff failing to watch the consumer's belt. The investigator stated it was not part of the investigation to determine if the facility had followed its own policies and procedures - or if the staff persons assigned to the consumer had been provided the information they needed in order to provide oversight to the consumer. DHSS concluded there was a limited extent to which this complaint was investigated. System failures were not identified in order to protect this consumer and any other consumers who are at risk for the same result, including if there were any policies or protocols for the transfer of consumers when in an agitated state. These failures included lack of

communication between the nursing staff and the driver of the van and assistant regarding instructions or measures needed to ensure safety, and facility failure to address safety issues in the consumer's habilitation plan. The Plan of Action did not include recommendations for the habilitation center to evaluate systems, ensure the staff persons transporting consumers are familiar with their safety needs and adaptive equipment, or to review the incident as a whole, rather than focusing on individual culpability.

Example: iiTS #35465 - On July 13, 2006, Consumer #1 was in the hospital and habilitation center staff did not provide appropriate supervision, resulting in the consumer removing his/her own IV. The staff person did not inform the nurse the consumer was attempting to remove the IV. During the course of the investigation, information gathered supported two counts of Class II neglect for the staff person regarding his lack of attention and supervision of the consumer. However, during the investigation it was also discovered the staff person had not been provided information regarding his role at the hospital and what his responsibilities included. Additionally the staff person did not receive instruction from the center regarding whom to report to for his lunch break. In this instance, there was more to the situation than the person's individual responsibility which should have been addressed. Review of the Plan of Action showed none of this information was included to ensure communication would be better in the future when staff are at the hospital with consumers.

On July 22, 2006, a second allegation of neglect was reported (iiTS#35640) due to staff sleeping and not providing supervision to prevent Consumer #1 from pulling off his/her restraints and from pulling out his/her IV. The staff person working with the consumer stated she had not been provided information regarding her role at the hospital, what her responsibilities included, information regarding why the consumer was in isolation and precautionary measures to take for the consumer and herself. If the facility had addressed their failure to provide better communication for their staff regarding the consumer's needs while at the hospital for their staff, this situation may have been avoided for the consumer the second time

- Identification of consumers who are at high risk for abuse and neglect and performing Root Cause Analysis to determine causal factors and develop plans to ensure their protection.

- Identification of those persons who have been abusive or neglectful in their care of consumers and identify the root cause of the offense in order to prevent reoccurrence.

- Recommend investigators routinely provide a Plan of Action to the facility superintendent to accompany completed investigations. The Plan of Action should contain areas identified by the investigator for which the habilitation center should review due to their impact on the investigation.

DMH investigators should be provided training and feel empowered by the department to identify areas which require the need for corrective action. Habilitation Center superintendents should provide a plan of correction in the areas identified. Such plans should include information identifying other consumers with the potential to be affected by the practice or actions of others, identification of system failure to protect the consumers, policies/procedures which were identified as not followed, monitoring of the Plan of Action, and also identifying who is ultimately responsible for making sure the Plan of Action items are corrected.

- DMH should evaluate its priority system to be more proactive in the investigation of abuse and to identity a system that promotes the health and safety of consumers served.

  This will require a different system for triaging complaints. All investigation inquiries should not be treated with equal urgency. Abuse of consumers is a serious allegation which requires a quick response in order to obtain information needed. Allegations of neglect are also important, however, if the habilitation center has acted appropriately by placing the staff on administrative absence and if there was no harm to the consumer as a result of a break in supervision, then an investigation is not of an immediate nature.

- DMH should ensure there is a reporting system for all to access in order to report instances of abuse or neglect within the habilitation center. The system should also provide for the confidentiality of reporters. All employees and guardians of the consumers at the habilitation center should be able to report allegations of abuse and neglect without fear of reprisal. Additionally, reports should be able to be made without the prior knowledge of the superintendent and the consent of the superintendent for investigation.

- DMH should evaluate the number of investigations completed by the Investigations Unit and determine the appropriate number of investigators needed in order to meet timeframes, without sacrificing the quality of the investigation.

  Interviews should be conducted within the first day of the investigation.

  Efficiency in the current interview process appeared to be lacking, namely the practice of accommodating facility staff based on their work hours and days of work. Often, frequent onsite visits to the facility were needed to complete interviews, continuing for several days. Alleged perpetrators or other witnesses did not always appear for their scheduled interviews. Immediate statements were not consistently obtained prior to placing the staff person on administrative absence, allowing time for multiple alleged perpetrators to work on providing a “consistent story”.

  The investigator should work with the habilitation center to ensure facility staff are aware of the importance of cooperating with an investigation. Cooperation with an

investigation is and should be a condition of employment. The habilitation centers should have a role in ensuring accurate contact information is obtained and maintained regarding their staff. Habilitation centers should assist in ensuring witnesses appear as scheduled, return phone calls, and not delay investigations. Witnesses and alleged perpetrators should be advised of the consequences of not cooperating with an investigation.

While there may be an efficiency in scheduling interviews when staff members are normally scheduled to work, doing so takes away time from their consumer care duties. Interviewing staff members when they are not scheduled to work would minimize time away from consumers.

Also, if persons are placed on administrative absence, an immediate statement should be taken by trained individuals regarding the alleged incident to determine if there are any inconsistencies in the alleged perpetrators statement with additional interviews. If this is not possible, then the supervisor placing the person on administrative absence should obtain a contact number where the alleged perpetrator can be reached within the next 48 hours.

- DMH should establish a training protocol for all investigators including review of policies and procedures, on the job training by supervisors, and implement a mentoring program teaming new investigators with seasoned investigators who have shown good investigation skills.

  DMH investigators should be required to complete training along with facility staff on the staff supervision levels, abuse and neglect training, and training on the Safety First manual, so they will have the same consistent information regarding these important issues including behavior plans and the use of restraints.

MATT BLUNT
Governor

STEVE RENNE
Interim Director

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September 27, 2006

MEMORANDUM TO STEVE RENNE, INTERIM DEPARTMENT DIRECTOR

From: Gus H. Kolilis, STAT Chief

Subject: Mental Health Task Force

Based on STAT's recent experience with Department of Mental Health (DMH) investigations, testimony heard during statewide public hearings, and professional literature reviews from across the country, the following preliminary suggestions are respectfully submitted:

The existing DMH Central Investigation Unit (CIU) is essentially a regulatory and policy enforcement group. They primarily investigate internal and external allegations concerning patient/staff events, and attempt to determine if Department policy was followed or violated. As investigators, they see little connection to client care and safety, unless it relates to policy violations. Only the most obvious criminality results in law enforcement involvement. Criminal investigations are seldom encouraged, even those that appear obviously suspicious. Since the vast majority of internal investigations involve client/employee allegations and denials, there appears to be a serious conflict of interest issue. CIU represents and protects the Department's interests, as opposed to identifying systemic issues.

There is a place for internal investigations, but the unit should operate in a culture of openness and honesty, versus minimizing and defensiveness. This culture can only result from clear expectations from the highest levels of the organization. It would also require re-visiting current policies and re-training the existing CIU. This training should be developed and provided by an external entity with the authority to implement changes.

The CIU could not only continue to provide internal investigations, but would be an integral part of the "triggering" mechanism for a Special Investigative Unit (SIU). This SIU would focus on major cases, including all fatalities, and would have no reporting responsibility to DMH administration. The SIU would report directly to the Mental Health Commission,, while CIU would continue to be aligned with DMH administration.

To establish SIU as a viable extension of the Mental Health Commission, would require the following:

- Unit to receive special training in the investigation of events involving the disabled.

- Evaluate and use trainers and curriculum specific to mental health and institutional investigations.

- Establish authority to investigate.

- Develop a protocol that defines and limits cases investigated by SIU, and how and when they are accessed.

  Example: Limit investigations to deaths, near deaths and other serious events. Victims would be limited to clients under the care, custody, control or direct supervision of DMH, and/or a contract provider (institutional or off-facility, but not those only receiving unsupervised financial or other support).

- The protocol should include a 24/7 triggering mechanism to activate SIU. It should also include specific levels of response, with parallel responsibilities for DMH Central investigators, institutional staff, etc.

  NOTE: There must be an overall acceptance that all staff, including investigators, have a responsibility to protect those who cannot protect themselves.

- SIU would investigate ALL client deaths (as defined above), to include those that are apparently natural, accidental or suspicious. Of particular concern, would be those events where serious injury and/or death is expected or anticipated. The timeliness of initiating the investigation and notifying appropriate external agencies (coroner/medical examiner, law enforcement, STAT, etc.) is paramount. In death investigations, autopsies should be encouraged.

- SIU would have complete authority to examine medical records, histories and other files, and to interview employees, family, etc.

- A reporting format should be developed to include times for preliminary information, updates and final report.

The Mental Health Commission should appoint a five member independent expert panel to review death and certain other investigative reports. The expert panel should include members from the following disciplines:

- Law Enforcement
- Forensic Pathologist
- Medical Doctor

- Mental Health Professional
- Institutional Social Worker

SIU would provide any additional assistance or support needed by the Commission or expert panel. A review of the investigation, including recommendations, could be provided to the Commission by the expert panel.

Child Deaths – STAT would continue to provide the existing services as detailed in the temporary 60-day plan. Additional services would be provided as needed and as resources will allow (data collection, training, etc.). Children are defined by statute as under 18 years of age (unless extended to age 21 by court order). The deaths of ALL children by any cause is evaluated by Missouri's Child Fatality Review Program (CFRP), and those where the cause of death is unknown, suspicious or of special concern, are reviewed in detail by a county multidisciplinary review panel.

- STAT, through training and direct contact, is encouraging local CFRP panel review of all DMH client deaths.

- STAT pays for most appropriate child autopsies, and is working with the Missouri Coroner/Medical Examiners Association to encourage autopsies of DMH client fatalities.

- STAT is providing special training for the entire child protection community to encourage their involvement and understanding in DMH issues.

- DMH care, custody, control or supervision of child deaths, STAT will do a complete investigation to be provided to the Mental Health Commission. STAT will work closely with SIU, but will present a separate report to the Commission on child fatalities, including a copy of the Child Fatality Review Program – Final Report. (The only public information allowed by statute.)

This investigative reorganization could be implemented and coordinated by units within the Missouri State Highway Patrol, the Department of Health and Senior Services and the Department of Social Services. Coordination of the reorganization should be external.

GHK/mrh092706

Department of Public Safety
MISSOURI STATE HIGHWAY PATROL
Colonel James F. Keathley, Superintendent

An Internationally Accredited Agency

Matt Blunt
Governor

Mark S. James
Director

October 4, 2006

Honorable Peter D. Kinder
Lieutenant Governor of Missouri
State Capitol, Room 121
Jefferson City, MO 65101

Dear Governor Kinder:

At the Missouri Mental Health Task Force meeting on Wednesday, September 27, 2006, task force members were asked to provide written recommendations to your office. It is the recommendation of the Missouri State Highway Patrol that the Department of Mental Health establish separate investigative arms to address different levels of allegations. One investigative arm, an internal affairs division, should handle complaints and allegations of violations of policies and procedures. The other investigative arm should review and investigate all deaths, allegations of assault, and allegations of criminal misconduct. These investigators should also have the ability to refer to local and state law enforcement to conduct joint investigations. These investigators should report directly to the Director of the Department of Mental Health or possibly the Missouri Mental Health Commission, which will add to the authority and accountability of this arm.

It is imperative the criminal investigators, whether these are employees or contracted investigators, have extensive experience in law enforcement and death investigations. Every unattended or suspicious death must be investigated. A coroner or medical examiner should be called to every unattended or suspicious death. Autopsies should be conducted by a forensic pathologist at the request of the coroner or the investigator. A fund should be established within the Department of Mental Health to assume the cost of autopsies to alleviate this cost on the part of the county. County funds or lack of county funds should not be a consideration for an autopsy.

A system should be established to ensure all incidents and allegations are reported and reviewed as quickly as possible. Please be assured the Highway Patrol will always be available and willing to offer assistance with criminal investigations. The Highway Patrol supports the concept introduced by the Missouri Mental Health Commission of placing video cameras in all state-operated Department of Mental Health Rehabilitation Centers.

I appreciate the opportunity for the Missouri State Highway Patrol to be a part of this task force.

Sincerely,

James F. Keathley

JAMES F. KEATHLEY, Colonel
Superintendent

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Dedicated to Service and Protection

APPENDIX F

Glossary and Definitions

Acronyms

ADA	Alcohol and Drug Abuse
CPS	Comprehensive Psychiatric Services
DMH	Department of Mental Health
DHSS	Department of Health and Senior Services
DOR	Department Operating Regulation
DPS	Department of Public Safety
DSS	Department of Social Services
FTE	Full Time Equivalent
ICF/MR	Intermediate Care Facility for those with Mental Retardation
ISL	Individualized Supervised Living
MOU	Memorandum of Understanding
MRDD	Mental Retardation and Developmental Disabilities
RSMo	Revised Statutes of Missouri
STAT	State Technical Assistance Team

Definition of Terms

Complainant -- Any person who files a complaint.

Complaint -- Allegation that class I neglect, class II neglect, misuse of funds/property, physical abuse, sexual abuse, or verbal abuse has occurred.

Consumer -- Individual receiving services from any facility operated by the Department, and may also be referred to as client, resident or patient.

Inquiry -- Process of gathering facts surrounding an event, complaint or upon discovery of unknown injury to determine whether the incident or event is suspect for abuse or neglect.

Medication Error -- A mistake in prescribing, dispensing, or administering medications. A medication error occurs if a consumer receives an incorrect drug, drug dose, dosage form, quantity, route, concentration, or rate of administration. This includes failing to administer the drug or administering the drug on an incorrect schedule. Levels of medication errors are:

- Minimal medication error is one in which the consumer experiences no or minimal adverse consequences and receives no treatment or intervention other than monitoring or observation;
- Moderate medication error is one in which the consumer experiences short-term reversible adverse consequences and receives treatment and or intervention in addition to monitoring or observation; and
- Serious medication error is one in which the consumer experiences life-threatening and/or permanent adverse consequences or results in hospitalization. Serious medication errors shall be investigated by the investigations unit as possible abuse or neglect.

Report of Physical, Sexual or Verbal Abuse, Neglect or Misuse of Funds/Property -- An allegation of physical, sexual or verbal abuse, neglect or misuse of funds/property that is based upon reasonable cause to believe that the allegation has occurred.

Definition of Abuse

Physical Abuse

- An employee purposefully beating, striking, wounding or injuring any consumer;
- In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management.

Sexual Abuse

Any touching, directly or through clothing by an employee of a consumer for sexual purpose or in a sexual manner. This includes but is not limited to:

- Kissing;
- Touching of the genitals, buttocks or breasts;
- Causing a consumer to touch the employee for sexual purposes;
- Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation;
- Failing to intervene or not attempting to stop inappropriate sexual activity or performance between consumers; and/or
- Encouraging inappropriate sexual activity or performance between consumers.

Verbal Abuse
An employee using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner to a consumer or about a consumer in the presence of a consumer.

Definition of Neglect

Class I Neglect
Failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result.

Class II Neglect
Failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidating, causing fear or otherwise creating undue anxiety.

The following can be Abuse or Neglect depending on circumstances

Misuse of funds/property -- The misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer.

Serious medication error -- In which the consumer experiences life-threatening and/or permanent adverse consequences or results in hospitalization.